

Health Care Professional

Family Physician: _____ Phone: (____) ____ - _____

Address: _____

Family Dentist: _____ Phone: (____) ____ - _____

Address: _____

Chiropractor: _____ Phone: (____) ____ - _____

Address: _____

(Other specialist, example: Physical Therapist, Naturopathic, Ophthalmologist, Pulmonary, etc.)

Address: _____

Medications

List medications and herbal supplements that you are currently taking and the reason.

(Example: Chlorthalidone Tabs 25mg. 1 Tablet daily for High Blood Pressure)

_____	_____
_____	_____
_____	_____
_____	_____

Allergies to Medications

List any medication(s) which have caused an reaction and the reaction it produced:

_____	_____
_____	_____

Surgeries

List all of your surgeries and hospital stays with the approximate dates and any complications:

_____	_____
_____	_____