

Date:
First name:
Last name:
SS#:

1) Have you seen a physician or other healthcare professional for any treatment or consultation? Yes _____ No _____

When? Why?

2) Have you suffered any illness or injury? Yes _____ No _____

3) Have you stopped, started or changed any prescription or over the counter medication or dietary supplement? Yes _____ No _____

4) Are you sensitive or allergic to latex? Yes _____ No _____.