ADDITIONAL PATIENT INFORMATION

DATE: _____

FIRST NAME: _____ LAST NAME: _____

SS#: _____

1. Have you seen a physician or other healthcare professional for any treatment or consultation? ▢ YES ▢ NO

   If yes, When? Why? _____

   _____

   _____

2. Have you suffered any illness or injury? ▢ YES ▢ NO

   Explain: _____

   _____

3. Have you stopped, started, or changed any prescriptions or over the counter medication or dietary supplement? ▢ YES ▢ NO

4. Are you sensitive or allergic to latex? ▢ YES ▢ NO