NAME:____________________________DATE:________

1. ALL MEDICATIONS/INHALERS (PRESCRIPTION AND OVER THE COUNTER)__________________________________
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2. ALL KNOWN DRUG ALLERGIES__________________________________
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3. PREVIOUS HOSPITALZATIONS/SURGERIES______________
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4. NAME OF YOUR CURRENT PHYSICIAN
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5. OTHER MEDICAL PROBLEMS__________________________________
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6. WHO MAY WE THANK FOR YOUR REFERRAL?
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