Patient Name:____ Date:_______________

DOB:____________________

Temperature:_____________

Health Status/History

Prescription Medications:____ ( ) None

Have you Taken Any Antibiotics/Antivirals In The Last 3 Days? ( ) No ( ) Yes If Yes, Which?___________________

Allergies to Medications____( ) None

Do You Currently Have Medical Problems Relation To:

( ) Heart ( ) Stomach/Bowel ( ) Eyes ( ) Fatigue

( ) Lungs ( ) Diabetes ( ) Ears ( ) High Blood Pressure

( ) Liver ( ) Skin ( ) Spinal/Brain ( ) Mental Illness

( ) Kidney ( ) Seizure ( ) Bladder/Urinary ( ) None/ Systems Negative

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Do You Have Any Autoimmune Diseases/Viruses? ( ) No

( ) Yes _____________________________

Are You Sick Today? ( ) No ( ) Yes If Yes, What are your symptoms?_______________________________

When Was Your Last Physical Exam?_______________________________

Have You Has Any Vaccinations In The Last 28 Days:__________________________

Women: When Was Your Last

Last Menstrual Period?_______________________

Currently Pregnant? ( ) No ( ) Yes

Breast Feeding? ( ) No ( ) Yes

Planning to become pregnant in the next 30 days? ( ) No ( ) Yes

Do You Have A Family History Of Any Significant Medical Problems/Diseases?

( ) No ( ) Yes (Please List)____

Have You Had This Vaccination Before? ( ) No ( ) Yes, If so, When?________________

If Yes, Did You Have Any Reaction To It? ( ) No ( ) Yes If so, What Kind Of Reaction?

____

Patient Signature:______________________________ Date:_____________________

Reviewed By:__________________________________ Date:_____________________