The Raphael Clinic of Maryland

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Name:_____
First Last

Address:_____
Street City State Zip code

Date of birth: __ __ / __ __ / __ __ __ __

Reason for appointment:

☐ Mistletoe infusions ☐ Vitamin C infusions ☐ Myers' Cocktail

Present medical issue(s):_____

Concomitant diagnosis: _____

Past medical history including surgeries: _____

Allergies:

Have you ever had nutritional infusions (If yes, please list and date): _____

Complete and updated list of medications and supplements with dosages (please use back, or attach list if you need more room) : _____

Sign: _____ Date: _____