AMISTAD CLINIC
100 E. 24th Street Suite 3-A
Yuma, AZ 85364

BRIEF MEDICAL HISTORY

Name _____
Phone _____Age _____Ht _____Wt_____
Address_____
City_____ State_____ Zip_____

MEDICATIONS:

_____
_____

ALLERGIES:

_____

Women are you pregnant or lactating? _____
Current Primary Care Provider_____

Circle any of the following illnesses you have or have ever had in the past (or family history):

Myasthenia Gravis	Hepatitis	Eye Disease
Numbness	Vision Problems	Muscle Weakness
Eaton Lambert Disorder	Autoimmune Disease	Amyotrophic Lateral Sclerosis (ALS)

I am not on Aminoglycosides or any other antibacterial medication to treat bacterial infections.
Explain: _____
_____

Previous Hospitalization/Operations:

_____
_____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Client Signature:

_____Date:_____