Patient Information Form

Medical History: Please check any medical conditions that apply to you:

- High Blood Pressure ☐
- Diabetes ☐
- Heart Disease ☐
- Cancer ☐
- Thyroid Disorders ☐
- Osteoporosis ☐
- Asthma ☐
- Chronic Obstructive Pulmonary Disease (COPD) ☐
- Allergies (Specify type): _____
- Arthritis ☐
- Autoimmune Disorder (Specify): _____
- Kidney Disease ☐
- Liver Disease ☐
- Gastrointestinal Disorders (Specify): _____
- Neurological Disorders (Specify): _____
- Mental Health Conditions (Specify): _____
- Sleep Apnea ☐
- Blood Clotting Disorders ☐
- Bleeding Disorders ☐
- HIV/AIDS ☐
- Sexually Transmitted Infections (Specify): _____
- Other Chronic Conditions (Specify): _____
- None ☐

Current Medications: List any medications you are currently taking.

- Medication 1: _____. Medication 2: _____
- Medication 3: _____. Medication 2: _____

Allergies: List any allergies you have, including medications, and foods.

- Allergy 1: _____ Allergy 2: _____
- Allergy 3: _____ Allergy 4: _____

Consent and Agreement: I hereby confirm that the information provided is accurate to the best of my knowledge. I understand that this information will be kept confidential and will be used for medical purposes only.

Patient's Signature: _____ **Date:** _____