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Name_____ Date of Birth _____/_____/_____
Last First MI

Do you smoke? □ Yes □ No If yes, daily amount _____

Allergies
Do you have any medicine (Rx) allergies? □ Yes □ No Type(s) of reaction: □ Rash □ Hives □ Swelling □ Anaphylaxis

Any other non - Rx allergies? □ Yes □ No Please describe _____

Please list all allergies below	Reaction

List all prescription medications (Or attach a legible personal list):

1 _____ 11 _____

2 _____ 12 _____

3 _____ 13 _____

4 _____ 14 _____

5 _____ 15 _____

6 _____ 16 _____

7 _____ 17 _____

8 _____ 18 _____

9 _____ 19 _____

10 _____ 20 _____
