**PATIENT INFORMATION UPDATE**

**EMAIL ADDRESS:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHARMACY**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PHONE#**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ADDRESS**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ALL MEDICATIONS YOU TAKE: BLOOD THINNERS? YES OR NO

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS OR DISEASES? PLEASE CIRCLE THOSE THAT APPLY:

**ABNORMAL BLEEDING**

KIDNEY PROBLEMS

ANGINAPECTORIS MITRAL VALVE

ARTIFICAL JOINTS PACE MAKER

**ARTIFICIAL HEART VALVE OR STENT** PHYSICATRIC PROBLEMS

ARTHRITIS SEIZURES

ASTHMA SINUS PROBLEMS

ALCOHOL ABUSE STROKE

CANCER (CHEMO / RADIATION) THYROID PROBLEMS

DIABETES (TYPE 1 / TYPE 2) **OSTEOPOROSIS**

DIFFICULTY BREATHING

EPILEPSY/SEIZURES

FEVER BLISTERS

FREQUENT HEADACHES

HEART RELATED ISSUES (PLEASE STATE)

**HEPATITIS (A / B / C)**

HIGH BLOOD PRESSURE ~MITRAL-VALVE PROLAPSE~PACEMAKER

HIV+ AIDS

LIST ANY **ALLERGIC REACTIONS** TO MEDICATIONS, ANESTHETICS, METALS, LATEX, ANTIBIOTICS OR OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone#**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THE INFORMATION GIVEN ABOUT MY HEALTH HISTORY IN THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I HEREBY GIVE CONSENT TO PERFORM NECESSARY DIAGNOSTIC TEST (INCLUDING X-RAYS) AND RELEASE OF THESE RECORDS TO SPECIALISTS OR INSURANCE CARRIERS, IF THE NEED ARISES.**

**I WILL BE RESPONSIBLE FOR REASONABLE ATTORNEY FEES INCURRED IN COLLECTION OF THIS ACCOUNT, IF NEEDED.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name Printed**

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**SIGNATURE DATE**