Name:_____ **Phone#:** _____

Name of Insured:_____

Address_____

City State Zip

Email_____**Weight:**_____ **Height:**_____

D.O.B._____

Preferred Pharmacy Name: _____

City or Zip code:_____

Past Medical History: (Please answer Y or N)

Arthritis _____	Depression _____	Heart Dx_____
Asthma _____	Diabetes _____	HIV/AIDS _____
Atrial fib _____	Renal Dx _____	Hypertension _____
Breast Ca _____	Hepatitis _____	Leukemia _____
Colon Ca _____	Melanoma_____	Lymphoma _____
Basal Cell Cancer _____	Squamous Cell Ca _____	Stroke _____

Other _____

Are You Currently Trying to Get Pregnant? _____

Past Surgical History: (Please answer Y or N)

Joint Replacement _____	Defibrillator _____
Blood Thinners _____	Heart Valve Replacement _____
Hx of MRSA/Staph Infection _____	Joint Replacement _____
Pacemaker _____	Antibiotics Prior To Surgery _____

Medications: (Please enter all current medications)

_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
_____
_____

Allergies: (Y or N)
Allergy to Adhesive _____
Allergy to lidocaine _____
Allergy to topical antibiotics_____
Allergy to epinephrine_____
OTHER ALLERGIES_____

Cigarette Smoking: (Y or N)
Currently Smokes _____
Has smoked in the past _____

Flu Shot This Year: (Y or N)_____