Current Meds: ____

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Allergies/Interactions: ____

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Medical History (Past and Current): ____

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____

Surgical History (Please Include Month/Year): ____

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____

Hospitalizations (Please Include Month/Year): ____

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____

____

Family History: Mother- ____

Father - ____

Grandparents- ____

Siblings - ____

Social History:

Smoke: Y N Quantity per day? ____________________

Caffeine Intake : Daily _____ Occasionally _____ Not at all_____

Alcohol Consumption: Daily_____ Occasionally _____ Socially_____ Not at all _____

Recreational Drug Use: ____

Exercise: ____

Special Diet: ____

Amount of Sleep Per Night: ____