

Name: _____ Date of Birth: _____

Person Completing Form: _____ Medical Doctor: _____

List Any Specialists You See: _____

Please List Any Allergies To Medications

Allergy To Latex: Y N

Medication Allergy	Reaction

Please List All Medications:

Medication	Dosage	Frequency

Please List Any Surgeries You Have Had:

Surgery	Date

Have You Ever Had an Anesthesia Reaction? Y N Type: _____

Did You Or Anyone In Your Family Ever Have a Reaction to Anesthesia called Malignant Hyperthermia? Y N

If Yes, Please Specify Who: _____

Have You Ever Had an Invasive Procedure That Wasn't Surgery? (i.e. Colonoscopy, Arteriogram, Cardiac Catherization)

Y N Type: _____

Are You Interested In Healing Touch? Y N (See Brochure)

Vaccinations: Please Circle Tetanus: When _____ Flu: When _____ Pneumonia: When _____ Other _____

Lyme Disease or Other Tick Borne Disease Y N

HIV Positive Y N

History of Exposure to Communicable Diseases Y N _____

Have You Had An Infection Called MRSA or VRE? Y N When: _____

Have You Had A Fever, Night Sweats, Cough, Bloody Sputum or Fatigue for More Than 3 WEEKS? Y N

Do You Smoke Y N If Yes, How Much _____ Or, When Did You Quit _____

Exposure To Second-Hand Smoke Y N Do You Use Other Types of Tobacco (i.e. Dipping, Cigars) Y N

