Please answer the following questions so we can update your health records

Name _____ Date _____

1. Please list any prescription medications and dosages that you are currently taking.

2. List any allergies to medications.

3. What is your height?

4. What is your weight?

5. Are you a smoker?

6. Are you a former smoker?

How would you like to receive information from our office?

Email (we will never share this information)

Phone

Mail

*Please print your email address clearly _____

SIGNATURE _____