

**What Medications are you taking/what for?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Do you take any Blood thinners?** NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOSE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you take Aspirin on a daily basis?** YES \_\_\_ NO \_\_\_

**What surgeries or operations have you had?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Are you allergic to any of the following?** \_\_ Adhesive Tape \_\_ Codeine \_\_ Iodine \_\_ Latex \_\_ Novocaine \_\_ Penicillin \_\_ Tetanus

**Do you have any other allergies or sensitivities?** YES \_\_\_ NO \_\_\_ If yes, what? \_\_\_\_\_\_\_\_

**Do you smoke?** YES \_\_\_ NO \_\_\_ If yes how many packs per day? \_\_\_\_\_

**Do you drink alcohol?** YES \_\_\_ NO \_\_\_ If yes: \_\_\_\_ Daily \_\_\_\_ Socially

**Are you pregnant?** YES \_\_\_ NO \_\_\_

**I certify that this information is correct, and I will notify Dr. Chapman of any changes in my medical history. Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**