Patient Name: ____ Date:________________________

Age:________ DOB:____________ Height:___________ Weight:____________________

What area(s) of improvement are you interested in?____

____

List any ED medications you are currently taking or have used in the past: ____

Did they work?:____

List any conditions/medical history you currently have or have had in the past:

List any known allergies: ____

When was the last time you saw a doctor for a physical exam? ____

List all medications and supplements you are currently taking:

Medications	Supplements

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omission that I may have made in the completion of this form.

Signature:____________________________ Date:________________