415 Business Park Lane, Allentown, PA 18109 | 610-844-7229

Brief Medical History

Name _____ Birthdate _____ Ht._____ Wt._____

Full Address _____

Phone _____ Email _____

Referred By _____ Primary Care Physician _____

Medication _____ **Allergies** _____

_____ _____

_____ _____

_____ _____

_____ _____

Personal History *Check if you have or have had any of the following illnesses.*

❑ Myasthenia Gravis ❑ Hepatitis ❑ Autoimmune ❑ Numbness ❑ Vision Problems ❑ Muscle Weakness

❑ ALS ❑ Eaton Lambert Disorder ❑ Other _____

Family History *Check if an immediate relative has or has had any of the following illnesses.*

❑ Myasthenia Gravis ❑ Hepatitis ❑ Autoimmune ❑ Numbness ❑ Vision Problems ❑ Muscle Weakness

❑ ALS ❑ Eaton Lambert Disorder ❑ Other _____

Are you taking Aminoglycosides or any other antibacterial medications to treat bacterial infections.

❑ No ❑ Yes If yes, please explain _____

Previous Hospitalizations/Surgeries _____

_____

_____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health, I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Client Signature _____ Date _____