**­Acupuncture Physicians of Colorado**

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***Acupuncture/Osteopathic Manipulative Therapy Questionnaire***

**(Please Print)**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Security Number: XXX- XX- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please provide your Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Workers’ Compensation, Pain Specialist or Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Chief Complaint / Why are you here? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Briefly describe how your injury occurred. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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***If this was an Auto Injury-***

**Was your seatbelt on? \_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_No**

**Did you lose consciousness? \_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_No**

**Did the airbag deploy? \_\_\_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_No**

**Did your vehicle hit anything else after the collision? \_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_ No**

**Did you see the accident coming (Did you brace yourself for impact?) \_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_ No**

**Make and Model of YOUR vehicle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Make and Model of the OTHER vehicle(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What was the damage to YOUR vehicle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What was the damage to the OTHER vehicle(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is your pain? \_\_\_\_\_\_\_Sharp \_\_\_\_\_\_\_Stabbing \_\_\_\_\_\_Cramp-like \_\_\_\_\_\_\_Tight \_\_\_\_\_\_Burning**

**\_\_\_\_\_\_\_Dull \_\_\_\_\_\_\_Achy \_\_\_\_\_\_Varies Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your pain move from place to place or radiate? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any numbing or tingling? Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list what makes your pain WORSE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Please list what makes your pain BETTER? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Circle a number to indicate the level of pain for this current injury. “0” on the left side of the scale represents**

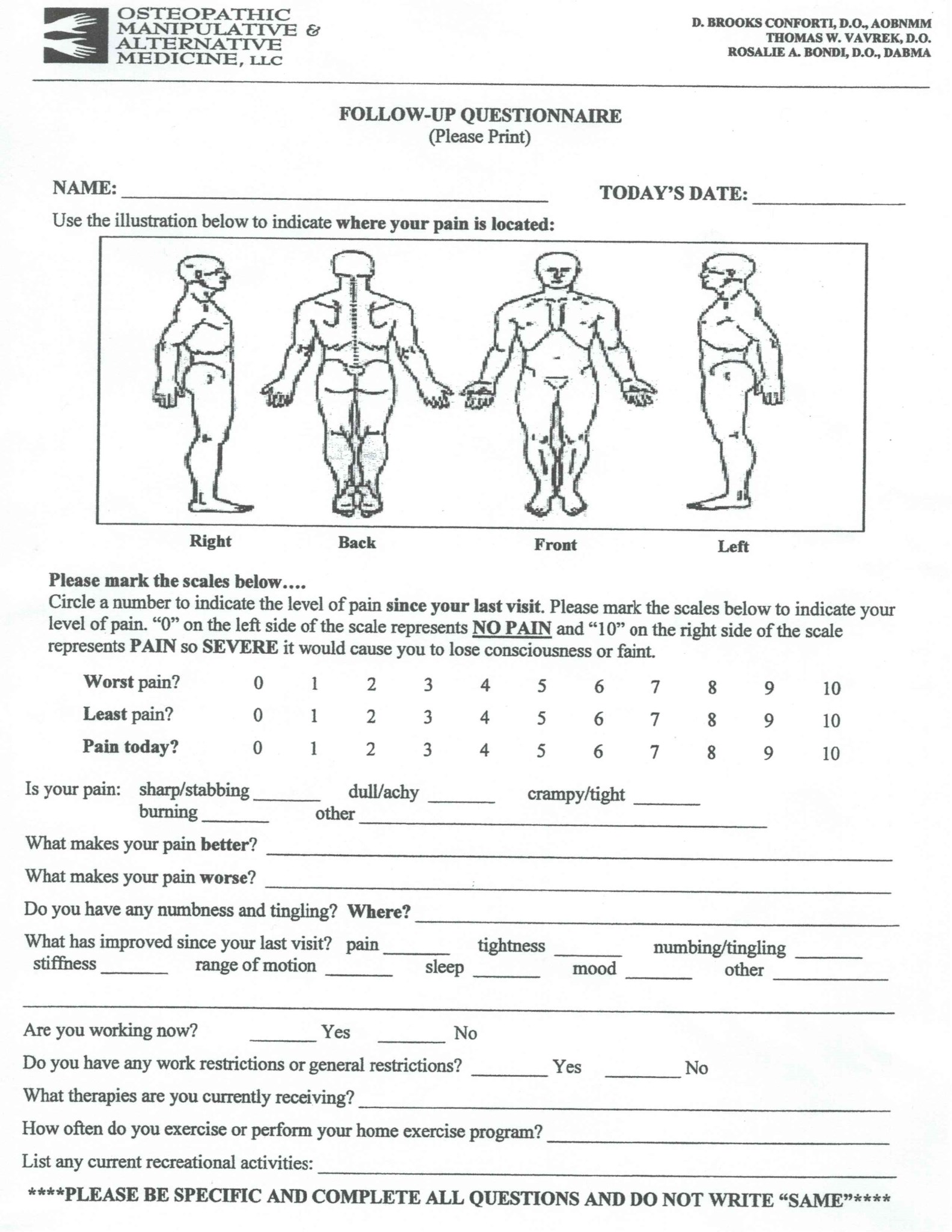
**NO PAIN and “10” on the right side of the scale represents PAIN so SEVERE *it would cause you to lose consciousness or faint.***

**WORSE PAIN? 0 1 2 3 4 5 6 7 8 9 10**

**LEAST PAIN? 0 1 2 3 4 5 6 7 8 9 10**

**PAIN TODAY? 0 1 2 3 4 5 6 7 8 9 10**

**WHERE IS YOUR PAIN? (Please use the illustration below to indicate where your pain is located)**



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**For THIS INJURY, what type of therapy have you received?**

**\_\_\_\_\_ Physical Therapy \_\_\_\_\_ Acupuncture \_\_\_\_\_ Massage \_\_\_\_\_ Biofeedback \_\_\_\_\_ Injections**

**\_\_\_\_\_ Osteopathic Manipulative Therapy \_\_\_\_\_\_ Chiropractic Therapy \_\_\_\_\_ Counseling**

**\_\_\_\_\_Other (Please Explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please state your exercise program and frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List the diagnostic tests completed for THIS condition:**

**Type of Test Approximate Date Done Where?**

**X-Rays \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CT-Scan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MRI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMG \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OCCUPATIONAL HISTORY**

**If you are currently working, what is your position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who is your current employer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently on work restrictions? Yes \_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_**

***If this is a workers’ compensation injury,* who was your employer at the time of injury? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***If this is a workers’ compensation injury*, what was your position at the time of injury? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REVIEW OF SYSTEMS**

**How many hours do you sleep per night? \_\_\_\_\_\_\_\_\_\_\_Hours**

**Do you have trouble falling asleep? \_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_No**

**Do you have trouble staying asleep? \_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_No**

**Do you feel well rested when you wake up \_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_No**

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**Please check any symptoms you have had over the past THREE MONTHS:**

**\_\_\_\_\_Fatigue \_\_\_\_\_Unexplained weight loss \_\_\_\_\_Memory problems \_\_\_\_\_ Vision problems**

**\_\_\_\_\_Headaches \_\_\_\_\_Balance problems/dizziness \_\_\_\_\_Depression \_\_\_\_\_Anxiety**

**\_\_\_\_\_Rash \_\_\_\_\_Nasal Congestion \_\_\_\_\_Shortness of Breath \_\_\_\_\_Chronic cough**

**\_\_\_\_\_Chest pain \_\_\_\_\_Bloody or Black stools \_\_\_\_\_Swollen ankles \_\_\_\_\_Muscle stiffness**

**\_\_\_\_\_Diarrhea \_\_\_\_\_Abdominal pain \_\_\_\_\_Constipation**

**\_\_\_\_\_Nausea/vomiting \_\_\_\_\_Urinary frequency/urgency**

**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***FOR FEMALES***

**\_\_\_\_\_Menstrual problems When was your last menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***IS THERE A POSSIBILITY YOU COULD BE PREGNANT?* \_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_No**

**PAST INJURIES**

**Have you had any other/prior *on-the-job injuries?* \_\_\_\_\_Yes \_\_\_\_\_No**

**If yes, please describe the injury AND list the date(s).**

**Injury Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Have you had any other/prior *auto accident injuries*? \_\_\_\_\_Yes \_\_\_\_\_\_No**

**If yes, please describe the injuries AND list the date(s).**

**Injury Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**SURGERIES**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAMILY MEDICAL HISTORY**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**YOURMEDICAL HISTORY**

**\_\_\_\_\_Addiction (Alcohol/Drug) \_\_\_\_\_Chronic neck pain \_\_\_\_\_High Cholesterol**

**\_\_\_\_\_Anemia \_\_\_\_\_COPD \_\_\_\_\_ HIV/AIDS**

**\_\_\_\_\_Anxiety \_\_\_\_\_Depression \_\_\_\_\_Kidney disease**

**\_\_\_\_\_Arthritis \_\_\_\_\_Diabetes \_\_\_\_\_Liver disease**

**\_\_\_\_\_Asthma \_\_\_\_\_Epilepsy/seizures \_\_\_\_\_Lupus**

**\_\_\_\_\_Benign Prostate Hypertrophy \_\_\_\_\_Fibromyalgia \_\_\_\_\_Migraines**

**\_\_\_\_\_Cancer \_\_\_\_\_Gout \_\_\_\_\_Multiple Sclerosis**

**\_\_\_\_\_Chronic back pain \_\_\_\_\_Environmental Allergies \_\_\_\_\_Osteoporosis**

**\_\_\_\_\_Chronic constipation \_\_\_\_\_Head injuries \_\_\_\_\_Stroke**

**\_\_\_\_\_Chronic diarrhea \_\_\_\_\_Heartburn \_\_\_\_\_Thyroid Disease**

**\_\_\_\_\_Chronic digestive problems \_\_\_\_\_Heart disease \_\_\_\_\_TMJ**

**\_\_\_\_\_Chronic fatigue \_\_\_\_\_Hemorrhoids Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_Chronic Headaches \_\_\_\_\_Hepatitis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_Chronic insomnia \_\_\_\_\_High blood pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL HISTORY**

**Do you presently smoke? \_\_\_\_\_No \_\_\_\_\_Yes How many *packs* per day? \_\_\_\_\_\_\_\_\_\_\_**

**Have you ever smoked? \_\_\_\_\_No \_\_\_\_\_Yes When did you quit smoking? \_\_\_\_\_\_\_\_\_**

**Do you drink alcohol? \_\_\_\_\_No \_\_\_\_\_Yes How many drinks per *WEEK?* \_\_\_\_\_\_\_**

**Have you ever been a heavy drinker? \_\_\_\_\_No \_\_\_\_\_Yes**

**Any recreational drug use? \_\_\_\_\_No \_\_\_\_\_Yes**

**What is your marital status? \_\_\_\_\_Single \_\_\_\_\_Married \_\_\_\_Divorced \_\_\_\_Separated**

**How many children do you have? \_\_\_\_\_\_\_\_\_\_\_ What is the last educational grade you completed? \_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATIONS**

**Please list any medications you are taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**ALLERGIES**

**Please list your allergies to medications:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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