Patient's name: Date:

Please list any current medications:

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Please list any allergies:

____

Please list any medical diagnosis: (i.e. Parkinson's, diabetes, cancer, etc.)

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____

Please list any surgeries:

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Have you ever been diagnosed with:

	YES	NO
Seizures?	☐	☐
Head injuries (such as a concussion)?	☐	☐
A stroke?	☐	☐
Heart problems?	☐	☐