CURRENT MEDICATIONS: **** Name:_____**

DATE:_____

MEDICATION STRENGTH FREQUENCY

ALLERGIES TO MEDICINES:

ENVIRONMENTAL ALLERGIES?_____

ARE YOU TAKING ASPIRIN ROUTINELY OR ARE YOU ON BLOOD THINNING MEDICATION?_____IF YES, WHAT?_____

ARE YOU ALLERGIC TO: **IODINE?_____**
SHELLFISH?_____

DO YOU HAVE THE FOLLOWING ILLNESSES?
DIABETES? _____HAYFEVER ?_____
ASTHMA?_____