# MEDICAL CHECK LIST

Name: ______________________________________

PLEASE COMPLETE THE FOLLOWING INFORMATION

List any known medication allergies, /check here if none: [ ]

| | |
|---|---|
| | |
| | |
| | |
| | |

List all medications you are currently taking, /check here if none: [ ]

| MEDICATION | DOSE | REASON | BEGAN |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

SUPPLEMENTS:

| | |
|---|---|
| | |
| | |
| | |

List all previous hospitalizations, or check here if none: [ ]

| Hospital | YEAR | REASON |
|---|---|---|
| | | |
| | | |
| | | |

PLEASE PROVIDE THE FOLLOWING DATES:

Last tetanus:________
Female: Last PAP test: ______________ Last Mamo: _______________

Do you consume alcohol: Y N if yes, how much? ________________ per day.
Do you smoke: Y N if yes, how many? ________________ per day.

**THREE-DAY DIET DIARY – LIST ALL FOOD AND DRINK THAT YOU TYPICALLY HAVE EACH DAY- INCLUDING SNACKS!**

| | DAY 1 | DAY 2 | DAY 3 |
|---|---|---|---|
| BREAKFAST | | | |
| LUNCH | | | |
| DINNER | | | |
| SNACKS | | | |

Comments:

____________________________________________________________

____________________________________________________________

***FAX NUMBER: 908-237-0210***