Medical Information Form

Patient information	
First name: Sarah	Last name: Parker
Date of birth: 06/15/1985	Gender: Female
Section one	
Are you pregnant or trying to get pregnant? ☐ Yes ☑ No ☐ Not applicable	
Are you taking oral contraceptives? ☑ Yes ☐ No ☐ Not applicable	
Are you taking any medication? ☑ Yes ☐ No ☐ Not applicable	
If yes, please explain:	
Ibuprofen (as needed for back pain), Levothyroxine (for thyroid condition)	
Do you use any tobacco? ☐ Yes ☑ No ☐ Not applicable	
If yes, please explain how often and how long have been using them:	
Do you use any controlled substances? ☐ Yes ☐ No ☐ Not applicable	
If yes, please explain what types of substances do you take, how often, and how long have you been taking them:	
Do you have any allergies? ☑ Yes ☐ No ☐ Not applicable	
If yes, please explain what you are allergic to, and what is the allergic reaction like:	
Penicillin — causes hives and swelling of the throat	