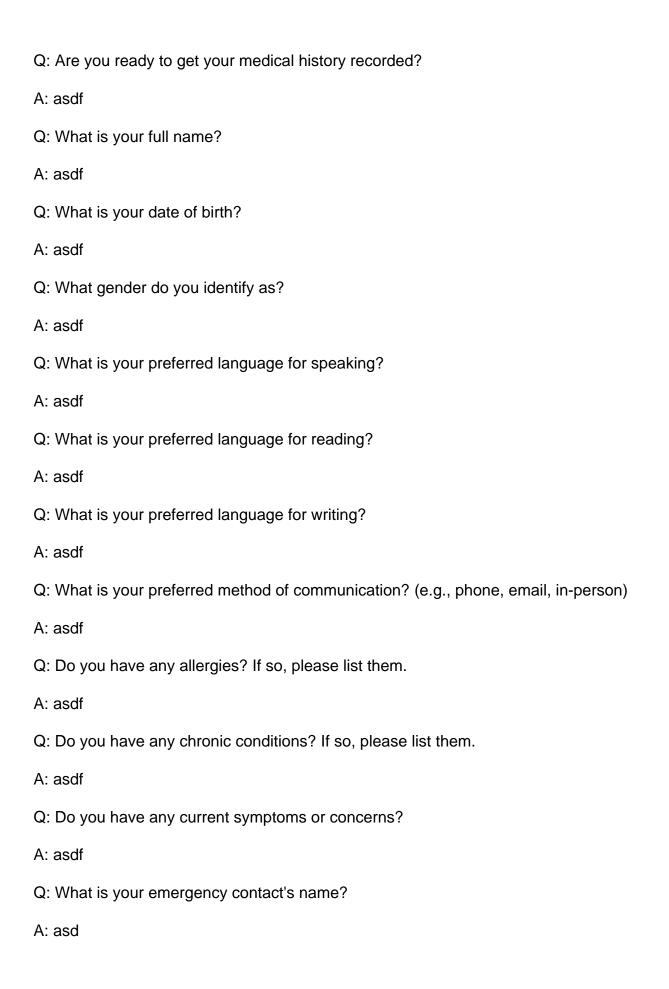
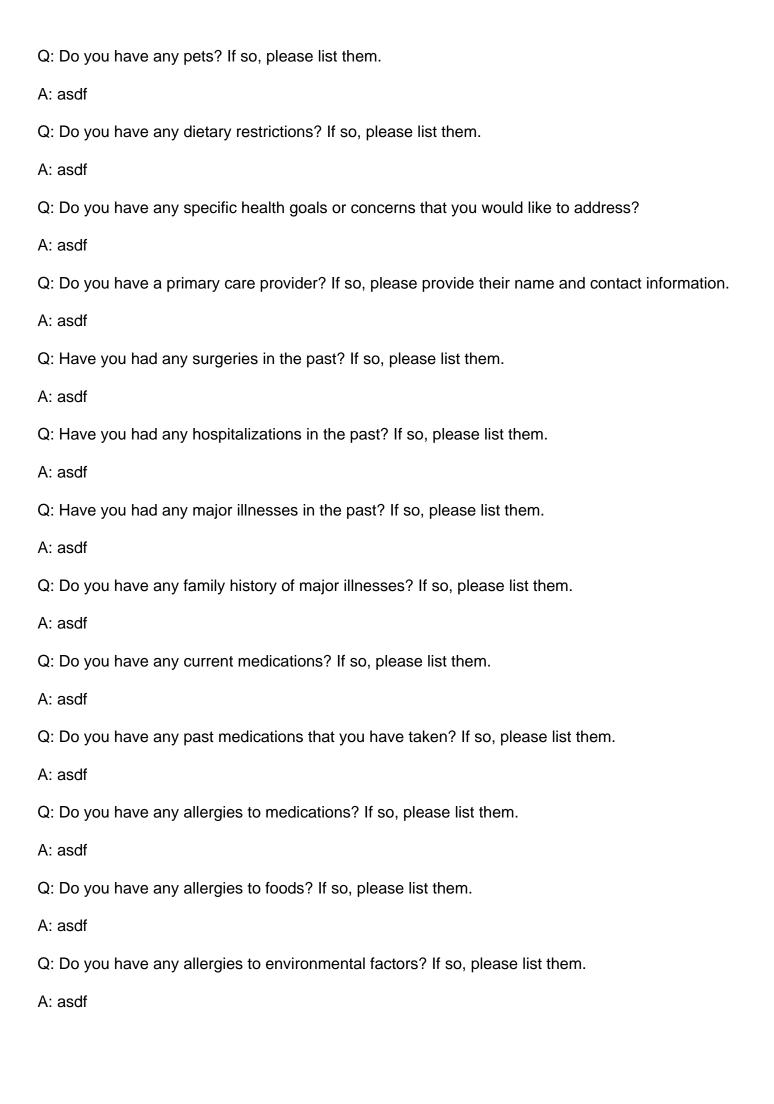
Patient History Summary



| Q: What is your emergency contact's relationship to you? |
|--|
| A: fasdf |
| Q: What is your emergency contact's phone number? |
| A: asdf |
| Q: What is your emergency contact's email address? |
| A: asdf |
| Q: Do you have a preferred pharmacy? If so, please provide the name and address. |
| A: asdf |
| Q: Do you have any health insurance? If so, please provide the name of the provider. |
| A: asdf |
| Q: What is your health insurance policy number? |
| A: asdf |
| Q: What is your health insurance group number? |
| A: asdf |
| Q: What is your occupation? |
| A: asdf |
| Q: What is your current employment status? (e.g., employed, unemployed, retired) |
| A: asdf |
| Q: What is your highest level of education? |
| A: asdf |
| Q: Do you have any disabilities? If so, please describe them. |
| A: asdf |
| Q: Do you have any special needs or accommodations that we should be aware of? |
| A: asdf |
| Q: Do you have any cultural or religious beliefs that may affect your healthcare? |
| A: asdf |
| |



| Q: Do you have any history of mental health conditions? If so, please describe them. |
|--|
| A: asdf |
| Q: Do you have any history of substance abuse? If so, please describe it. |
| A: asdf |
| Q: Do you have any history of domestic violence or abuse? If so, please describe it. |
| A: asdf |
| Q: Do you have any history of sexual abuse or assault? If so, please describe it. |
| A: asdf |
| Q: Do you have any history of trauma or PTSD? If so, please describe it. |
| A: asdf |
| Q: Do you have any history of self-harm or suicidal thoughts? If so, please describe it. |
| A: asdf |
| Q: Do you have any history of eating disorders? If so, please describe it. |
| A: asdf |
| Q: Do you have any history of sleep disorders? If so, please describe it. |
| A: asdf |
| Q: Do you have any history of chronic pain? If so, please describe it. |
| A: asdf |
| Q: Do you have any history of heart disease? If so, please describe it. |
| A: asdf |
| Q: Do you have any history of lung disease? If so, please describe it. |
| A: asdf |
| Q: Do you have any history of liver disease? If so, please describe it. |
| A: asdf |
| Q: Do you have any history of kidney disease? If so, please describe it. |
| A: asdf |
| |

| Q: Do you have any history of gastrointestinal disease? If so, please describe it. |
|--|
| A: yes |
| Q: Do you have any history of neurological disease? If so, please describe it. |
| A: yes |
| Q: Do you have any history of autoimmune disease? If so, please describe it. |
| A: yes |
| Q: Do you have any history of cancer? If so, please describe it. |
| A: yes |
| Q: Do you have any history of diabetes? If so, please describe it. |
| A: yes |
| Q: Do you have any history of hypertension? If so, please describe it. |
| A: yes |
| Q: Do you have any history of high cholesterol? If so, please describe it. |
| A: yes |
| Q: Do you have any history of stroke? If so, please describe it. |
| A: yes |
| Q: Do you have any history of seizures? If so, please describe it. |
| A: yes |
| Q: Do you have any history of thyroid disease? If so, please describe it. |
| A: yes |
| Q: Do you have any history of asthma or other respiratory conditions? If so, please describe it. |
| A: yes |
| Q: Do you have any history of allergies or allergic reactions? If so, please describe it. |
| A: yes |
| Q: Do you have any history of skin conditions? If so, please describe it. |
| A: yes |
| |

Q: Do you have any history of eye conditions? If so, please describe it.

A: yes

Q: Do you have any history of hearing conditions? If so, please describe it.

A: yes