Lipotropic B-12 'Skinny Shot' Patient History Form

(Fill out 1-11)

1. Name:_______________________________________ 2. DOB:_____________

3. Address:

Street_________________________________City:__________________State:_______Zip:____________

4. Phone number: ________________________ 5. Email:________________________

6. Primary Care Provider:__________________Phone:_______________Specialty:________

7. Past Medical History (circle all that apply):

High blood pressure Diabetes Heart Disease Reflux

Seasonal Allergies High Cholesterol Cancer Stroke Insomnia

Other (write in):

8. Medications (list all): ____

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9. Medication allergies: ____

10. Are you allergic to the following (circle all that apply):

benzyl alcohol sulfur lidocaine cobalt

11. Do you have a personal history of any of the following (circle all that apply):

Leber's Herreditary Optic Neuropathy Megaloblasti Anemia Chronic Liver Disease Kidney failure

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12. Temperature______F Pulse______ BP_____/______ Weight_______lbs Height____ft____in BMI____

13. Circle: Approved Denied

14. Signed by Dr. Pastorek ____________________ **Date**_________________