Refine
BY FARRELL
Suzanne Arcuni Farrell, APRN

Name:_____

Date of birth:_____

Home town and zip:_____

Email:_____

Phone:_____

Allergies:_____

Medications within the past 7 days:_____

Referred by:_____

<u>Medical History: please CIRCLE all that apply</u>:

Current Pregnancy **Bleeding issues/disorder**

Heart issues **Oral Herpes/cold sores**

High or low Blood Pressure **Dermatology issues**

Breathing issues **Trouble swallowing**

Diabetes **Fainting, seizures, other neurologic issue**

recent or pending DENTAL work

AUTOTIMMUNE issues: _____

COVID vaccine:

<u>If NONE, please circle</u>: NONE

Have you ever had head, neck or facial surgery? Yes No

If you answered YES to any medical history or surgery questions or have any other significant health issues, please list below:

In case of emergency please contact:

_____ phone:_____

The information I have provided is complete and accurate:

_____ date:_____

I have reviewed Refine By Farrell's Privacy Practices under the "About" tab on refinebyfarrell.com

_____ date:_____