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## **Return Patient Medical History and Demographics Update**

Please fill this out completely and return to us by fax or hand-carry to your appointment.

Name:				Home Phone:		
Address:				Cell Phone:		
				Work Phone:		
Reason for toda	ay's visit:					
Medications (p		the counter, and vita:				
Name	Dose	Frequency	Name	Dose	Frequency	
Drug or Food	Allergies?	None				
Name Rea			Reaction			
Are you <b>Allerg</b>	gic to IV Contras	t? Yes	No Have 1	never received/Do	n't know	
Any new chang	ges to your medica	al history since you l	ast saw us? Yes	No		
Any recent sur	rgeries?	Yes No				