STEUBENVILLE CHIROPRACTIC

Operations: Please circle all that apply

Appendectomy	Gallbladder	Hysterectomy
Prostate	Tonsillectomy	Other _____

Allergies (Please list):

1)_____ 2) _____ 3) _____ 4) _____

Please list all prescription medications and over the counter medications (OTC), vitamins, supplements or minerals that you are taking. List name and dosage of each medication (50 MG tablet 2x/day). You may use the bottom and/or back if you need more space.

Prescription Medications	**OTC, VITAMINS,MINERALS**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____