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):

    benzly alcohol   sulfur   lidocaine   cobalt

11. Do you have 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. Starr** __________________________________ Date. _____________________