



Medical History Form

Patient Information

Name:			
Height:		Weight:	
Phone:			
Email:			
Address:			
City, State ZIP:			

Medical History

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Medications

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Allergies

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Surgeries / Hospitalizations

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Patient Consent

I certify that the information provided is accurate to the best of my knowledge. I understand that this information will be used by trt of erie to provide appropriate medical care. I authorize the release of this information to healthcare providers as necessary for my treatment.

Patient Signature

Signature:		Date:	
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