Patient's Name: _____ **DOB:** _____

CURRENT MEDICATIONS, OVER THE COUNTER MEDICATIONS VITAMINS AND HERBS

PHARMACY NAME AND PHONE NUMBER _____

Name of Medication	Dosage (mgs)	Times per day

ALLERGIES/REACTIONS: _____

_____

HIV TESTING:

We are required by New York State Law to offer HIV testing. Are you interested in counseling and HIV testing?

YES _____ NO _____

HEPATITIS C TESTING:

We are required by New York State Law to offer Hepatitis C testing if you are born between the years of 1945-1965. Are you interested in counseling and Hepatitis C testing?

YES _____ NO _____

CHAPERONE:

Would you like a nurse/chaperone present at the time of your exam:

YES _____ NO _____

_____

Patient Signature Patient Name Date