DETAILED INFORMATION: ADULT

Name:			DOB:/ M F
Height:	Weight:	Hair Color:	Eye Color:
Employer Name: _			
Address:			Phone:
Wear eyeglasses o	r contacts? Y N		
			vare (list conditions such as diabetes,
high blood pressui	re, pacemaker, Alzheii	mer's, etc.):	
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Prescription medic	cations currently takir	ng:	
Other important ir	nformation:		
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high blood pressui	re, pacemaker, Alzheii	mer's, etc.):	
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Any known allergie	es? If so, list:		
Droscription modic	eations currently takin	og:	
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Other important in	nformation:		

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