Lumicera Patient Health History Form

www.lumicera.com / 1.855.847.3553
fax: 1.855.847.3558
contact@lumicera.com

Patient Information	
Name:	Preferred phone: ☐ Work ☐ Cell ☐ Home
Address:	Alternative phone: ☐ Work ☐ Cell ☐ Home
Date of birth (mm/dd/yyyy):	Sex (male/female):
Weight (in pounds):	Height:
Are you pregnant, nursing or planning pregnancy (check one)? ☐ Yes ☐ No ☐ N/A	

Specialty Prescriber Information	
Name:	Phone:
Specialty:	Approximate date of last visit:

Health Information
Other medical conditions:
Allergies and reactions to allergies (e.g. rash, hives, facial swelling):

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Current Medications (include over-the-counter drugs and herbal supplements)

Medication name	Date you started taking medication	Frequency	Dose	Route (oral, inhaled, injection, etc.)	Condition for which medication is prescribed

Please fax or mail completed form to:

Lumicera Health Services
310 Integrity Drive
Madison, WI 53717
Fax: 1.855.847.3558