

MEDICAL CONSENT AND RELEASE FORM

Client's Name _____

Insurance Carrier/ Phone number/Account number _____

Age ____DOB____/____/____ Gender: (M) (F) Women: Date of Last Menstrual Cycle: ____/____/____

Address _____

Smoker/How much per day? _____ Drink Alcohol/How much per day? _____

Past Hospitalizations or Surgeries? List & Date _____ / ____ / ____

_____ / ____ / ____

Within Costa Rica alone or accompanied? (YES) (NO) Emergency Contact _____

Have you ever been diagnosed or do you presently suffer from:	YES	NO	TREATMENT
High blood pressure			
Diabetes			
Asthma			
Cough frequently or have shortness of breath			
Epilepsy			
Frequent headaches or migraine			
Hepatitis			
Lung problems or illness			
Liver problems or illness			
Heart problems or illness			
Kidney problems or illness			

Date of Last Tetanus Shot: _____

Allergies:

LIST SPECIFICS	YES	NO
Drugs		
Food		
Plants		
Animals		
Bee/Insect stings		
Dietary Restrictions		
Other		

Medications: Is Patient currently taking medications?

Explain: _____

Drug Name

Dosage

Other
