GAINSWave®

Patient Name: _____ Date:_____

Age:_____ DOB:_____ Height:_____ Weight:_____

What area(s) of improvement are you interested in?_____

_____

List any ED medications you are currently taking or have used in the past: _____

Did they work?:_____

List any conditions/medical history you currently have or have had in the past:

List any known allergies: _____

When was the last time you saw a doctor for a physical exam? _____

List all medications and supplements you are currently taking:

Medications	Supplements

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omission that I may have made in the completion of this form.

Signature:_____ Date:_____