Medical History

Check Conditions you currently have or had:

[] AIDS	[] Chemical dependency	[] High cholesterol	[] Polio
[] Alcoholism	[] Chicken pox	[] HIV positive	[] Prostate problem
[] Anemia []Anorexia/Bulimia [] Appendicitis [] Arthritis	[] Diabetes [] Emphysema [] Epilepsy [] Glaucoma	[] Kidney Disease [] Liver Disease [] Measles [] Migraine headaches	[] Psychiatric care [] Rheumatic fever [] Scarlet Fever [] Stroke
[] Asthma [] Bleeding disorders	[] Goiter [] Gout	[] Miscarriage [] Mononucleosis	[] Suicide attempt [] Thyroid problems
[] Breast Lumps	[] Heart disease	[] Multiple Sclerosis	[] Tuberculosis
[] Bronchitis [] Cancer	[] Hepatitis [] Hernia	[] Mumps [] Pacemaker	[] Ulcers [] Vaginal Infections
[] Cataracts	[] Herpes	[] Pneumonia	[] STD's
LAST COLONOSCOPY:	LAS	ST BONE DENSITY:	
LAST PROSTATE EXAM	М:LA	ST MAMMOGRAM:	
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Medicine	ons (include Over the	e Counter, Herbals and V Dose/Fr o	deprendent metallistation communication of the comm
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Please list all physicians (specialis	ts, homeopathic, therapists, etc.) invo	olved in your care:
1. Physician Name & Specialty:		
Practice Name:		
Address:		
Phone #:	Fax#:	
2. Physician Name & Specialty:		
Practice Name:		
Address:		
Phone #:	Fax#:	
Practice Name:		
Address:		
	Fax#:	
Practice Name:		
Address:		
	Fax#:	
Practice Name:		
Address:		
Phone #:	Fax#:	