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MEDICAL HISTORY FORM - Page 1 of 2

Name: _____ DOB: _____Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Work: _____

Email: _____ Job: _____ Relationship Status: _____

Education Level: _____ Preferred Pharmacy: _____

Emergency Contact: _____ Emergency Contact Phone #: _____

FAMILY MEDICAL HISTORY				
	Yourself	Father	Mother	Siblings
High Blood Pressure				
High Cholesterol				
Diabetes				
Heart Disease/Heart Attack				
Cancer				
Lung Disease (Asthma/COPD)				
Thyroid Disease				
Autoimmune Disease				
Stroke				
Osteoporosis				
Alcoholism/Addiction				
Depression or Psychiatric Disease				
Other (specify):				
Check if Deceased				

Medications and dosages (including vitamins/herbs):

Specialists:

Drug Allergies: _____

Operations and past hospitalizations: _____