MEDICAL HISTORY

Name and address of your regular physician	·
Approximate date of last visit with your regular physician	
Please list conditions for which you are now under treatment, or treat yourself.	
Medications you are presently taking including herbs, nutrition	nal supplements and/or diet pills:
Do you smoke cigarettes or consume alcohol? If so, how mu	nch:
Allergies - Please list Medicine Allergies	Other Allergies
Penicillin? Kidney Dye?	
If needed, will you accept a blood transfusion?	Blood Products?
Are you now, or have you in the past six months received any	r treatment from an alternative care provider (chiropractor, acupuncture, etc.).
If so, please list:	
PREVIOUS SURGERIES -	
PREVIOUS HOSPITALIZATIONS, NON SURGICAL - Please	list the reason for hospitalization and year.
Diagnosis:	