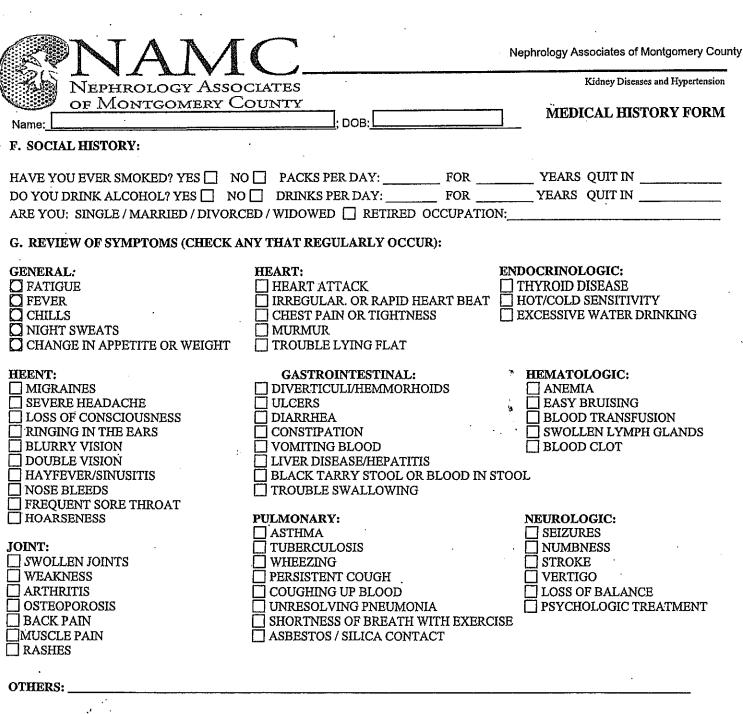




MEDICAL HISTORY FORM

PLEASE FILL OUT THE FORM AS ACCURATELY AS POSSIBLE. THE INFORMATION WILL BE ENTERED INTO YOUR PERMANENT RECORD

NAME:	DOB:	
A. DO YOU HAVE: YES NO M.I	D. NOTES	YES NO M.D. NOTES
KNOWN KIDNEY DISEASE URINATION AT NIGHT STREQUENT URINATION SURNING ON URINATION SINUSITIS SPROTEIN / FOAMY URINE SLOOD IN URINE SLOOD IN URINE KIDNEY STONES		S (Neuropathy)
B. LIST MEDICAL PROBLEMS WITH APPROXIMATE YEAR WHEN DIAGNOSE	C. PLEASE LIST MEI D: AND HERBA	DICINEŞ INCLUDING OVER THE COUNTEI LS AND/OR BRING TO CLINIC VISIT:
Medical Problem 1. 2. 3. 4. 5. 6. 7. 8. 9.	1. 2. 3. 4. 5. 6. 7. 8.	tion with dose and frequency per day
D. ALLERGIES AND TYPE OF REACTION: E. FAMILY HISTORY:		NO Relationship



Notes (for office use only):