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Address (with city & zip) E-mail address Telephone numbers Date of birth & gender Occupation & who referred you Emergency contact & telephone Physician's name & telephone Health Information Y N Y N Allergies Are you on a blood thinner Are you on a diuretic
Telephone numbers Date of birth & gender Occupation & who referred you Emergency contact & telephone Physician's name & telephone Health Information Y N Y N Allergies Are you on a blood thinner List all operations & major illnes
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Allergies
Allergies
Asthma Are you on a diuretic
Back pain Do you have a pacemaker
Blood pressure irregularities Are you pregnant or trying to get pregnant
Diabetes Are you currently under a doctor's care
Emotional challenges List any other health problems below
Headaches Headaches
Heart problems Heart problems
Inflammation
Menstrual irregularities Menstrual irregularities
Shortness of breath Shortness of breath
Swelling of limbs

Signature _____

Today's date: _____