Premier Health SC Medical Information Form

D.O.B:	Name:		Date:		
Abdominal Pain Alzheimer's Asthma Blood in Stools Epilepsy Bronchitis	D.O.B:				
Abdominal Pain Alzheimer's Asthma Blood in Stools Epilepsy Bronchitis					
Abdominal Pain Blood in Stools Blood in Stools Bilepsy Bronchitis Diverticulitis Headaches Chronic Coughing Hemorrhoids Multiple Sclerosis Emphysema Heartburn Seizures Pneumonia Frequent Diarrhea Frequent Constipation Liver Disease ENDOCRINE CARDIAC Muscul Osketetal Thyroid Condition Palpitations Heart Attack What type Chest Pain Heart Failure Gout Diabetes Heart Attack Stroke Osteoporosis Prostrate Problems High Cholesterol Swollen Ankles High Blood Pressure RENAL Kidney Disease What type What type What type What type Bleeding Disorders Frequent Urinary Tract Infections Glaucoma Depression SURGERIES IN THE PAST (Please Circle) Tonsillectomy Appendectomy Gallbladder Carotid Endarterectomy Varicose Veins Heart Surgery Back Surgery Bypass in the Legs Colon Surgery Prostrate Surgery Mastectomy Eye Surgery Hysterectomy Tubal Ligation Joint Replacement Other MEDICATIONS STRENGTH DOSE 1. 2. 3.	Please check or circle	any symptoms you ha	ve or have had:		
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LIST OF ALLERGIES AND REACTIONS (SWELLING, MAUSEA, ETC.) 1
LIST OF ALLERGIES AND REACTIONS (SWELLING, MAUSEA, ETC.) 1
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DO YOU SMOKE? YES/NO DO YOU DRINK? YES/NO
Daily amount Weekly amount
FAMILY HISTORY: Medical illness such as diabetes, heart attack, TB, high blood pressure,
Stroke cancer, Alzheimer's, Parkinson's, kidney disease, asthma, arthritis, gout
AGE ILLNESS
Father
Vother
Brother's
Sister's
Children NAME DATE OF BIRTH IF DECEASED AGE/CAUSI
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2.
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