# HEALTH HISTORY INFORMATION

## Personal Information

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

E-Mail: _____

Age: _____ Sex: _____ Weight: _____ Ideal Weight: _____

Emergency Contact: _____

*Please complete in as much detail as possible:*

| | Date | Description |
|---|---|---|
| Surgery(ies): | | |
| | | |
| | | |
| | | |
| | | |

| | Name/Brand | Dosage | Comments |
|---|---|---|---|
| Supplements/ Medications: | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Comments

Pain: _____

_____

_____

_____

_____

_____

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