MEDICAL HISTORY:

Have you had or	, ,							
Arthritis	☐ Asthma	☐ Backaches		oression	☐ Diabete		ating Disorde	
☐ Hay Fever	Headaches	☐ High Blood I	Pressure	☐ High Ch	olesterol	Pregnancy	Cthe	•
Other, pleas								
	ken tetracyclines, o hs or longer, or 4 or			tics, or corti	sone type	Yes	□ No	
Have you had ma	ajor surgery? 🏻 🔼 Y	res 🖸 No						
If yes, pleas	e list							
Do you have a fa	mily history of:							
☐ Alcoholism	☐ Cancer	☐ Diabetes	☐ Hea	art Disease	☐ High Ch	nolesterol	Kidney Dise	ase
☐ High Blood Pr	essure	y 🗖 Oste	oporosis	Respirat	tory Conditio	ns		
Other, pleas	e list:							
Any known food								
☐ Milk	☐ Wheat ☐	Corn	Nuts	☐ Seaf	ood \Box	Other	☐ None	
Other, pleas	e list:							
	er allergies? \(\Gamma\) Y e list:							
Do you have any	known food sensiti	vities? Lactose ir	ntolerance,	gluten intol	erance etc.	□ Ye	es 🖸 No	
	known food sensiting amalgam fillings?	vities? Lactose in			erance etc.		es 🖸 No	
Do you have any		☐ Yes ☐ N	lo If ye	es, how ma	ny?			
Do you have any	amalgam fillings?	Yes Nointestinal distres	lo If yess: gas, blo	es, how ma	ny?stipation etc.			
Do you have any	amalgam fillings? symptoms of gastr on any medications	Yes Nointestinal distres	lo If yess: gas, blo	es, how ma	ny?stipation etc.	? \[\]Ye	es 🖸 No	
Do you have any Do you have any Are you currently	amalgam fillings? symptoms of gastr on any medications	Yes Nointestinal distres	lo If yess: gas, blo	es, how ma	ny?stipation etc.	? \[\]Ye	es 🖸 No	
Do you have any Do you have any Are you currently If yes, please list	amalgam fillings? symptoms of gastr on any medications: taking any supplen	Yes Nointestinal distress? Birth control,	lo If yess: gas, blo	es, how ma	ny?stipation etc.	? \[\]Ye	es 🖸 No	
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Do you have any Do you have any Are you currently If yes, please list Are you currently If yes, please list What is your bloce PERSONAL HAI What activities d Do you like to co How often do you Do you have cult If yes, what kind' Please mark if ap	amalgam fillings? symptoms of gastr on any medications: taking any supplent: and type? A Pos BITS: by you like / regularly ok? Yes u eat out? ural/ethnic food pre	C Yes C No ointestinal distress? Birth control, nents? C Yes C A Neg C No C No C Vegeta	lo If yes ss: gas, blood thyroid, steed thyroid, st	es, how man pating, conservides, aspir	ny?stipation etc. in, other? AB Pos	? CYes	es C No	CON
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