NAME:

Medical History

Prepared for:

Date:

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YOUR NAME	
SUMMARY	
CURRENT TREATMENTS	MEDICATIONS

DIAGNOSES/SYMPTOMS

Diagnosis/Symptom	Doctor	Date and details

SYMPTOM DETAILS Dermatological	
Vascular	
Neurological	
Gastrointestinal	
Muscular	
Skeletal	

NAME:		
Endocrinological		
Urinary		
Respiratory		
Immunological		
Gynaecological		
Rheumatological		

FLARE LAB RESULTS

Date	Test Type	Details	High	Low

ALLERGIES AND SENSITIVITIES

Allergy	Reaction
Sensitivity	Reaction

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MAJOR ILLNESSES

Illness	Tests	Treatment	Year

SURGERIES

Procedure	Physician	Year	Result

Procedure	Physician	Year	Result

FAMILY HISTORY

Family Member	Diagnoses

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PHYSICIANS CONSULTED

Field	Physician	Treated/ Reviewed	Year