<u>5 Year Medical History Report</u>

Medical/Doctors seen in past 5 years (please add to second page, if necessary)

Primary Physician/Phone ____
Address ____
City, State, Zip____

Name/Phone ____
Address ____
City, State, Zip ____

Name/Phone ____
Address ____
City, State, Zip____

Name/Phone ____
Address ____
City, State, Zip____

Primary Physician/Phone ____
Address ____
City, State, Zip____

Primary Physician/Phone ____
Address ____
City, State, Zip____

Medications Taken, Dosage, and Condition ____
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____

Primary Physician/Phone ____
Address ____
City, State, Zip____

Name/Phone ____
Address ____
City, State, Zip ____

Name/Phone ____
Address ____
City, State, Zip____

Name/Phone ____
Address ____
City, State, Zip____

Primary Physician/Phone ____
Address ____
City, State, Zip____

Name/Phone ____
Address ____
City, State, Zip ____

Name/Phone ____
Address ____
City, State, Zip____

Name/Phone ____
Address ____
City, State, Zip____