

Edenic-Light Integrative Family Life Care™

c/o 3695F Cascade rd #117, Atlanta Ga. 30331

Phone; 678-592-7289 fax 1-866-357-6267 www.edenic-light.com

Medical History Form(Flu Pandemic Form Only)

For Emergencies Dial 911

Patient Information

Updated:

First Name:	MI:	Last Name:	SSN:
Address:		City:	Zip:
Date of Birth:		Age:	Male: Female:
Phone Number:		Place of Work:	

Physician's Information:

Physician's Name:	Physicians Phone:
Hospital Preference:	Insurance Company: n/a

Emergency Contact:

Name:	Relationship:
Phone Number:	

Past & Existing Medical History

Blood Type: ____ **Weight** ____ **Height** ____

Medical Conditions or injuries:(diabetes, anemia, high blood pressure, stroke, aids, kidney disease, liver disease, pregnant etc.....)

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Allergies: Including Food, Medical, Herbal

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Current Medications: including Herbal Supplements, Anti-depressants

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Are u having Flu symptoms now ____ **if yes list** _____

Circle applicable: chills, nausea, vomiting, chest pain, coughing, phlegm, fever, stomach pains, running nose, respiratory problem, dizziness, headache etc.....**Are u Pregnant?** _____

I certify that to the best of my knowledge that I have disclosed all medical conditions, medications and allergies _____