

APPLICATION & PATIENT MEDICAL HISTORY

COMPLETE AND FAX TO 1-866-481-5816 OR MAIL TO 8702A MEADOWLARK ROAD, EDMONTON, ALBERTA, CANADA T5R 5W4



Who will the prescriptions be for?

First Name _____ Last Name _____

Street Address _____ City _____ State _____ Zip Code _____

Email Address _____ Yes, send me the MC newsletter via email containing special offers, promotions and health related information (FREE).

Tel () _____ Fax () _____ Business () _____

Date of Birth (dd/mm/yyyy) _____ Height (ft/inch) _____ Weight (lbs) _____ Gender: Male Female

Have you had a physical examination in the last 12 months? Yes No

(To process your order, it is mandatory to have had a physical examination in the last 12 months)

Please check any current medical conditions and illnesses that apply to you.

Heart Condition or Blood Pressure Yes No

- Angina Arrhythmia
- Atrial Fibrillation Heart Attacks
- Congestive Heart Failure High Blood Pressure
- Mitral Valve Disease Stroke (CVA)
- Other: _____

Respiratory Condition Yes No

- Allergic Rhinitis Asthma
- Chronic Bronchitis Emphysema
- Other: _____

Diabetes, Thyroid, Endocrine Condition

- Yes No
- Diabetes Type 1 Diabetes Type 2
- Hyperthyroidism Hypoglycemia
- Hypothyroidism Thyroid Disease
- Other: _____

High Cholesterol Yes No

If Yes, diagnosed at what age: _____

Is it a common problem in your family?

- Yes No
- High Triglycerides Other: _____

Colon or Prostate Disorders Yes No

- Benign Prostatic Hypertrophy
- Colon Disorders Other: _____

Gastrointestinal Yes No

- Acid Reflux/Gerd Hiatal Hernia
- Stomach Ulcers Rectal Bleeding
- Lactose Intolerance Black Stools
- Ulcerative Colitis Crohn's Disease
- Irritable Bowel Syndrome
- Other: _____

Cancer Yes No **If yes, please specify type:**

Neurological or Psychological Yes No

- Anxiety
- Attention Deficit Disorder (ADD)
- Bipolar disorder Depression
- Insomnia Migraines
- Panic Disorder Epilepsy
- Parkinson Other: _____

Muscle, Bone or Joint Disorder Yes No

- Arthritis Back/Spine Disorders
- Gout Osteoporosis
- Other: _____

Chronic Illness Yes No

- Chronic Fatigue Syndrome Fibromyalgia
- Chronic Pain Multiple Sclerosis
- Other: _____

Kidney or Liver Disorders Yes No

- Renal (kidney) Failure Require dialysis
- Hepatitis Cirrhosis of the Liver
- Other: _____

Eye Disorders Yes No

- Glaucoma Cataracts
- Retinal Problems Other: _____

Other Medical Conditions Yes No

- Acne AIDS
- Anemia Eczema/Psoriasis
- Smoking
Amount per day _____
How many years _____
- Alcohol (How often _____)
- Menopause Pregnancy
- Blood Disorders Herpes Simplex
- Obesity
- Sleeping Pills/Tranquilizers
- Other: _____

If you answered YES to any of the above questions please elaborate in the area below

(i.e. duration of illness, any treatment or surgery received)

PATIENT FAMILY HISTORY

(include your parents and siblings)

Diabetes, thyroid or other endocrine disorder Yes No
Relationship _____

Breast Cancer Yes No
Relationship _____

Hypertension (high blood pressure) Yes No
Relationship _____

Cardiovascular (heart or artery disease) Yes No
Relationship _____

Lipid (cholesterol) disorder Yes No
Relationship _____

Prostate Cancer Yes No
Relationship _____

Other forms of Cancer Yes No
Relationship _____

Migraine Headaches Yes No
Relationship _____

Other illnesses not previously noted:

Please list any pills or medications you are CURRENTLY taking (drugs, natural or herbal supplements, vitamins and all other forms of medication):

Please list all known allergies below (including drug allergies):

