



NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ M \_\_\_ F \_\_\_

ADDRESS: \_\_\_\_\_ DL#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ EMAIL: \_\_\_\_\_

RESPONSIBLE FOR BILL: \_\_\_\_\_

REFERRED BY: \_\_\_ FRIEND \_\_\_ FACEBOOK \_\_\_ WEBSITE \_\_\_ RADIO \_\_\_ OTHER: \_\_\_\_\_

**MEDICAL HISTORY:** \_\_\_\_\_

**HISTORY OF OPERATIONS:**

DIABETES Y \_\_\_ N \_\_\_

CANCER Y \_\_\_ N \_\_\_

HIGH BLOOD

PRESSURE Y \_\_\_ N \_\_\_

HEART PROBLEMS Y \_\_\_ N \_\_\_

ASTHMA Y \_\_\_ N \_\_\_

THYROID DISORDER Y \_\_\_ N \_\_\_

SEIZURE/EPILEPSY Y \_\_\_ N \_\_\_

STROKE Y \_\_\_ N \_\_\_

ANEMIA Y \_\_\_ N \_\_\_

HEPATITIS Y \_\_\_ N \_\_\_

OTHER Y \_\_\_ N \_\_\_

List other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS (INCLUDING OVER THE COUNTER)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

LAST MENSTRUAL  
CYCLE: \_\_\_\_\_

**DRUG ALLERGIES:** \_\_\_\_\_

SMOKING : Y \_\_\_ N \_\_\_

ALCOHOL: Y \_\_\_ N \_\_\_

\_\_\_\_\_

I HAVE COMPLETED THIS FORM WITH HEALTH DISCLOSURE INFORMATION THAT IS ACCURATE, COMPLETE, AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT MEDITRIM OF EAST TEXAS, LLC WILL NOT BE HELD MEDICALLY RESPONSIBLE FOR ANY OMITTED INFORMATION. I UNDERSTAND MEDITRIM OF EAST TEXAS, LLC RESERVES THE RIGHT TO DENY PARTICIPATION FOR ANY REASON, MEDICAL OR OTHERWISE. I AGREE TO NOTIFY MEDITRIM OF EAST TEXAS, LLC OF ANY CHANGES TO MY MEDICATIONS, HEALTH AND/OR FITNESS THAT MAY OCCUR BEFORE OR DURING THE PROGRAM.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_