□ Convulsions       □ Diarrhea       □ Chronic cough         □ Dizziness or Fainting       □ Distension of abdomen       □ Difficult breathing         □ Headache       □ Gall bladder trouble       □ Spitting up blood         □ Numbness       SKIN         ■ Numbness       EYES, EARS NOSE & THROAT       □ Bruise easily         ■ Arthritis       □ Ear noises       □ Dryness         □ Bursitis       □ Eye pain       GENITO-URINARY         □ Sout trouble       □ Sinus infection       □ Bed-wetting         □ Neck pain or stiffness       □ Sinus infection       □ Bed-wetting         □ Pain between shoulders       □ High blood pressure       □ Inability to control kidneys         □ Sciatica       □ Low blood pressure       □ Kidney infection or stones         □ Swollen joints       □ Pain over heart       □ Painful urination         □ Shoulders       □ Pain over heart       □ Prostate trouble         □ Arms       □ Slow heart beat       □ Irregular cycle         □ Lumps in breaset	Name:	He	ight: Weight:	
Was It for This Ailment? Yes No. Were Any Other Doctors Consulted for This Ailment? Yes No If So, Please List Them:  What Was the Doctor's Diagnosis for Your Ailment? Did It Help? Yes No No It So, Please List Them:  What Was His Prescribed Treatment? Did It Help? Yes No	Please describe your problems as accu	urately as possible:		
Was It for This Ailment? Yes No. Were Any Other Doctors Consulted for This Ailment? Yes No If So, Please List Them:  What Was the Doctor's Diagnosis for Your Ailment? Did It Help? Yes No No It So, Please List Them:  What Was His Prescribed Treatment? Did It Help? Yes No				
If So, Please List Them:  What Was the Doctor's Diagnosis for Your Aliment?  What Was His Prescribed Treatment?  Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.  O - OCCASIONAL F - FREQUENT  O F GENERAL   GASTRO-INTESTINAL   Chest pain   Chronic cough   Chronic cough   Chronic cough   Chest pain   Chronic cough   Chest pain   Chest pain   Chronic cough   Chest pain   Chest pain   Chronic cough   Ch	Name of Your Family Doctor:		Date of Last Visit:	
What Was the Doctor's Diagnosis for Your Aliment?	Was It for This Ailment?Yes _	No. Were Any Other Doctors Consult	ed for This Ailment?Yes	No
What Was His Prescribed Treatment?	If So, Please List Them:			
Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.  O — OCCASIONAL F — FREQUENT  O F GASTRO-INTESTINAL OF RESPIRATORY Chest pain Convulsions or constipation Diarrhea    Allergy	What Was the Doctor's Diagnosis for \	our Ailment?		
Conversion   Con	What Was His Prescribed Treatment?		Yes _	No
O F GASTRO-INTESTINAL Constitution Convisions Convision	Please check the appropriate box for a facts about your health before we accommod to the second seco	ny of the following symptoms which you nov ept your case. THIS IS A CONFIDENTIAL H	v have or have had previously. We wa EALTH REPORT.	ant all the
GASTRO-INTESTINAL Consultations Convulsions Convulsion		O — OCCASIONAL F — FREQUE	NT	
Please list any surgery:	GENERAL  Allergy Convulsions Dizziness or Fainting Headache Neuralgia Numbness MUSCLE & JOINT Arthritis Bursitis Denot trouble Dow back pain Neck pain or stiffness Denot between shoulders Sciatica Swollen joints Pain, numbness or cramps Shoulders Arms Detect Physical examination Blood test Chest x-ray Spinal x-ray Dental x-ray	GASTRO-INTESTINAL  Constipation Diarrhea Distension of abdomen Gall bladder trouble Pain over stomach EYES, EARS NOSE & THROAT Earache Ear noises Eye pain Nasal obstruction Sinus infection CARDIO-VASCULAR High blood pressure Dow blood pressure Pain over heart Poor circulation Rapid heart beat Slow heart beat HABITS Alcohol Coffee Tobacco	RESPIRATORY  Chest pain Chronic cough Chronic cough Stire in plood SKIN Bruise easily Dryness Skin eruptions (rash) GENITO-URINARY Bed-wetting Blood in urine Frequent urination Inability to control kidneys Kidney infection or stones Painful urination Prostate trouble FOR WOMEN ONLY Irregular cycle Lumps in breast Menstrual cramps Pregnant Yes No Date of last period	
I HAVE READ ALL OF THE ABOVE STATEMENTS AND HAVE ANSWERED TO THE BEST OF MY KNOWLEDGE.	Please list any surgery:  Please list medication now taking:			