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MEDICAL HISTORY Patient: Birthdate: Today's Date: Address: City: Phone: Employer: Employer Address: Your  
current physical health is: Good Fair Poor Physicians (Medical Doctor) Name: Pl...

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CARLYN PHUCAS PEDIATRIC ORTHODONTICS ASSOCIATES Health History Update Form Patients Name: Date of  
Birth: Today's Date: Home Phone: Cell Phone: Health Changes: New Allergies: Recent Hospitalizations: Has  
Insurance Changed? Yes No-If yes please ask for a Change of Insurance Form Current Medications: ...

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Name DuPont Family Vision Clinic, PLLC MEDICAL HISTORY QUESTIONNAIRE SOCIAL HISTORY Current Occupation :  
Years Employer SPECTACLE LENS HISTORY Do you use a computer? Yes No How many hours day? Distance from  
Computer? Do you drive? Yes No Mileage to work each way? Do you have glare problems? Yes No Do you have  
visual difficulty when driving? Yes No Do you have problems with night vision? Yes No Do you...

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Student Health Services Medical History Form Name: Date: Age: Date of Birth: (  
The following information is confidential and will be used only by your medical provider to enhance the level of personal care.)  
Are you allergic to any medications? Yes No o If yes, please list medication and reaction:  
Are you currently taking over-the-counter medications, prescription medicines (including birth control),  
vitamins, supplements or homeopathic remedies...

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