

Name _____

Home Phone _____

Cell Phone _____

Email Address _____

Please indicate all known health conditions that apply to you and members of your immediate family, including parents, grandparents and siblings, below:

| Health Condition | Me | Age of onset/Type | Family Member(s) | Age of onset/Type |
|-----------------------|----|-------------------|------------------|-------------------|
| Alzheimer's Disease | | | | |
| Arthritis | | | | |
| Asthma/Allergies | | | | |
| Aneurysm | | | | |
| Blood Clots | | | | |
| Blood Disorder(s) | | | | |
| Cancer: | | | | |
| Breast | | | | |
| Colon | | | | |
| Prostate | | | | |
| Lung | | | | |
| Other | | | | |
| Diabetes | | | | |
| Epilepsy | | | | |
| Eye Condition(s) | | | | |
| Heart Disease | | | | |
| High Blood Pressure | | | | |
| High Cholesterol | | | | |
| Kidney Disease | | | | |
| Leg Cramps/Food Ulcer | | | | |
| Lung Disease | | | | |
| Osteoporosis | | | | |
| Psychiatric Disorder | | | | |
| Seizures/Epilepsy | | | | |
| Smoking | | | | |
| Stroke | | | | |
| Thyroid Disorder | | | | |
| Tuberculosis | | | | |
| Ulcer | | | | |

List any other major illnesses, surgeries, treatments or conditions, including those related to military service: _____

MILES LAZERWITZ, DDS

PLEASE FAX TO: 201-447-4951