# NEW BEGINNINGS COUNSELING & CONSULTING LLC

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**Newark, De 19702**

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## Medical History (Attach any lab results or consultation reports as appropriate)

**Surgeries (List separately)** **Date** **Outcome**

**Chronic Illnesses (Check all that apply)**

| | Self | Family | Date of diagnosis |
|---|---|---|---|
| **Diabetes:** | | | |
| **Hypertension:** | | | |
| **Cancer:** | | | |
| **Epilepsy/Seizures:** | | | |
| **Asthma:** | | | |
| **Heart Disease:** | | | |
| **Stroke:** | | | |
| **Lung Disease:** | | | |
| **Headaches/Migraines:** | | | |
| **Arthritis:** | | | |
| **Other (List):** | | | |

**Allergies (Leave blank if you have none) Reactions:**

**Medications:**

**Food:**

**Environmental:**

**Other:**

**Medications (Prescribed and OTC)**

**Current (List Separately)** **Dose** **Date Started** **Refills** **Prescribing MD**

**Past (List Separately)** **Dose** **Date Started** **Refills** **Prescribing M**