



ORDER FORM

Name: _____ Phone Number (____) _____ Date _____

Ship to Address _____

Apt. _____

City _____ State _____ Zip Code _____

Date of Birth _____ Gender _____ M _____ F _____ Height _____ Weight _____

Requested Medications	Dosage	Quantity	Price
Shipping			\$ 13.00
Total			

Patient Medical History:

Drug Allergies: _____

- | | | | |
|--|----------------|--|----------------|
| a) Blood Disorder | ___ Yes ___ No | g) Upper respiratory disorders | ___ Yes ___ No |
| b) Cancer | ___ Yes ___ No | h) Smoker | ___ Yes ___ No |
| c) Renal or Kidney Disease | ___ Yes ___ No | i) Emotional Disorder | ___ Yes ___ No |
| d) Neurological Disorders | ___ Yes ___ No | j) Glaucoma | ___ Yes ___ No |
| e) Hyperlipidemia (high cholesterol) | ___ Yes ___ No | k) Stomach, Liver, Intestine Disorder | ___ Yes ___ No |
| f) Heart Disease including blood pressure, heart disease, angina, heart failure, heart attack, surgery | ___ Yes ___ No | l) Thyroid, diabetes or other endocrine disorder, including insulin resistance | ___ Yes ___ No |
| | | m) Arthritis | ___ Yes ___ No |

Are you a new customer? ___ Yes ___ No

Would you like generics if available? ___ Yes ___ No

Do you need child proof caps? ___ Yes ___ No (If "Yes" please be aware the we cannot guarantee original manufacturer-sealed containers, as the manufacturer doesn't always bottle prescriptions in child proof caps)

List every medication you are currently taking: _____

Payment ___ MasterCard ___ Visa ___ Money Order / Personal Check # _____ Name on Card: _____ Credit Card # _____ Expiration _____

Please sign: _____ Date: _____

(Your Credit Card and Order Authorization Signature)