

Health Matters INTERNATIONAL

Group Code New Customer Order Form

Customer Name: _____

Mailing Address: _____

City: _____ State/Prov.: _____

Country: _____ Zip/Postal Code: _____

Home Phone: () _____ Other Phone: () _____

Primary Physician:

Name: _____ Phone: () _____

Other Physician:

Name: _____ Phone: () _____

Other Physician:

Name: _____ Phone: () _____

List Any Allergies or Conditions: _____

Request Medication	Brand, Generic, Branded Generic	Dosage	Quantity (maximum 3 months supply)	Country Product Ordered From

Ship this order with another person's Order? (Name): _____

I hereby waive my right to pharmacy counseling, as I have been previously counseled regarding the above mentioned. (Optional)

Please do not contact me regarding this order, but rather ship the medication as described above. (Optional)

Payment Method: Mastercard VISA

Name on Card: _____

Credit Card #: _____ Exp: _____

Signature: _____ Date: _____

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Group Code New Customer Medical History Form Continued

6. Your Personal Medical History

Blood Disorders	Yes	No	Orthopedic or Muscle Disease	Yes	No
Cancer	Yes	No	Mental Disorders	Yes	No
Immune Disorders	Yes	No	Surgical Procedures	Yes	No
Pound Wound Healing	Yes	No	Glaucoma	Yes	No
Neurological Disorders	Yes	No	Addictions - Chemical	Yes	No
Hormone Disorders	Yes	No	Arthritis, Lupus, Connective Tissue Disease	Yes	No
Nutritional, Mineral, Electrolyte Imbalance	Yes	No	Smoker	Yes	No
Lipid/Cholesterol Disorder	Yes	No	Lung Disease	Yes	No
Heart/Circulation Disease	Yes	No	Airway Disease	Yes	No
Kidney/Urinary Disease	Yes	No	High Blood Pressure	Yes	No
Liver Disease	Yes	No	Other Conditions (List Below)	Yes	No

7. Other Conditions: _____

8. Return Policy: By law, no returns are possible.

9. I certify that the information provided is complete and accurate.

Signature: _____ Date: _____

Please fax this form to Health Matters International at:

Toll Free: 1-866-453-0909