MANINDER S. GURAM, MD
TOMBALL GASTROENTEROLOGY ASSOCIATES
155 SCHOOL ST, STE 250
TOMBALL, TX. 77375
PH: (281) 205-7522 FAX: (281) 205-7553

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY _____ ST _____ ZIP _____

SOCIAL SECURITY: _____-_____-_____ EMAIL: _____

HOME PHONE: _____ CELL PHONE: _____ CAN WE TEXT YOU: _____

LANGUAGE: _____ ENGLISH ____ SPANISH RACE (CHECK ALL THAT APPLY): ____ ASIAN _____ BLACK _____ WHITE

ETHNICITY: _____ MARITAL STATUS: ___MARRIED ___SINGLE ___DIVORCED ___SEPARATED ___WIDOW

SEXUAL ORIENTATION: _____ STRAIGHT/HETEROSEXUAL _____ LESBIAN/GAY/HOMOSEXUAL _____ BISEXUAL

GENDER IDENTITY: ___ MALE ____ FEMALE ____TRANSGENDER MALE TO FEMALE ____ TRANSGENDER FEMALE TO MALE

___ GENDER NON-CONFORMING

ASSIGNED SEX AT BIRTH: ____ MALE ____ FEMALE PRONOUNS: ____ HE/HIM ___ SHE/HER ____ THEY/THEM

PRIMARY CARE PHYSICIAN NAME: _____

PRIMARY CARE PHYSICIAN ADDRESS/PRACTICE NAME: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

EMERGENCY CONTACT HOME PHONE: _____ CELL PHONE: _____

PATIENT EMPLOYER: _____ PHONE: _____

OCCUPATION: _____ INDUSTRY: _____

ASSIGNMENT AND RELEASE

I CERTIFYTHAT I, AND/OR MY DEPENDENT(S) HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO DR. GURAM ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY REPSONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.

THE ABOVE NAMED PHYSICIAN MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE NAME INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

PLEASE PRINT YOUR NAME RELATIONSHIP TO PATIENT IF A MINOR

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MEDICATION REFILLS

IF YOU NEED A REFILL ON MEDICATION, PLEASE FIRST CONTACT YOUR PHARMACY. PLEASE CALL ONE WEEK PRIOR TO NEEDING YOUR REFILL AS WE NEED 24-48 BUSINESS HOURS TO REFILL ANY MEDICATIONS. IF A PRIOR AUTHORIZATION IS REQURED, YOU WILL BE RESPONSIBLE FOR CALLING YOUR INSURANCE COMPANY.

PHARMACY INFORMATION

PHARMACY NAME: _____

PHARMACY ADDRESS (OR CROSS STREETS/INTERSECTION): _____

PHARMACY PHONE NUMBER: _____

PATIENT INSURANCE INFORMATION

PRIMARY INSURANCE:

INSURANCE NAME: _____ INSURANCE ADDRESS: _____
CITY ST ZIP

INS PHONE: _____ MEMBER ID: _____ GRP/POLICY: _____

INSURED NAME: _____ RELATION TO PATIENT: SELF SPOUSE PARENT OTHER

INSURED DATE OF BIRTH: ____/____/____ SOC SEC #: ____-____-____

SECONDARY INSURANCE:

INSURANCE NAME: _____ INSURANCE ADDRESS: _____
CITY ST ZIP

INS PHONE: _____ MEMBER ID: _____ GRP/POLICY: _____

INSURED NAME: _____ RELATION TO PATIENT: SELF SPOUSE PARENT OTHER

INSURED DATE OF BIRTH: ____/____/____ SOC SEC #: ____-____-____

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REQUEST FOR RELEASE OF MEDICAL RECORDS

DATE: _____

TO: _____
PRIMARY CARE PHYSICIAN'S NAME

_____
ADDRESS

_____
CITY STATE ZIP

_____
PHONE NUMBER FAX NUMBER

ALL RECORDS CONSULTATION NOTES LAB WORK HOSPITAL RECORDS/DISCHARGE PATHOLOGY REPORT

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RLEASED TO:

DR. MANINDER GURAM
TOMBALL GASTROENTEROLOGY ASSOCIATES
155 SCHOOL ST, STE 250
TOMBALL, TX. 77375
PH: (281) 205-7522 FAX: (281) 205-7553

_____ _____/_____/_____
PATIENT'S NAME (PLEASE PRINT) PATIENT'S DATE OF BIRTH

_____
ADDRESS

_____
CITY STATE ZIP

SOCIAL SECURITY #: _____-_____-_____

PATIENT'S SIGNATURE: _____ DATE: _____/_____/_____

PATIENT HIPAA CONSENT FORM

OUR NOTICE OF PRIVACY PRACTICES PROVIDES INFORMATION ABOUT HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU. THIS NOTICE CONTAINS A PATIENT RIGHTS SECTION DESCRIBING YOUR RIGHTS UNDER THE LAW. YOU HAVE THE RIGHT TO REVIEW OUR NOTICE BEFORE SIGNING THIS CONSENT. THE TERMS OF OUR NOTICE MAY CHANGE. IF WE CHANGE OUR NOTICE, YOU MAY OBTAIN A REVISED COPY BY CONTACTING OUR OFFICE.

BY SIGNING THIS FORM, YOU CONSENT TO OUR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ABOUT YOU FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS. YOU HAVE THE RIGHT TO REVOKE THIS CONSENT IN WRITING, SIGNED BY YOU. HOWEVER, SUCH A REVOCATION SHALL NOT AFFECT ANY DISCLOSURES WE HAVE ALREADY MADE IN RELIANCE ON YOUR PRIOR CONSENT. THE PRACTICE PROVIDES THIS FORM TO COMPLY WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).

THE PATIENT UNDERSTANDS THAT:

PROTECTED HEALTH INFORMATION MAY BE DISCLOSED OR USED FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

THE PRACTICE HAS A NOTICE OF PRIVACY PRACTICES AND THAT THE PATIENT HAS THE OPPORTUNITY TO REVIEW THIS NOTICE.

THE PATIENT RESERVES THE RIGHT TO CHANGE THE NOTICE OF PRIVACY POLICIES.

THE PATIENT MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME AND FUTURE DISCLOSURES WILL THEN CEASE.

I AUTHORIZE THAT YOUR OFFICE CONTACT ME AT (_____)_____ HOME WORK CELL.

I, _____, DO HEREBY GRANT PERMISSION FOR THE RELEASE OF ANY AND ALL INFORMATION, WRITTEN AND/OR VERBAL, REGARDING MY MEDICAL CONDITION, INCLUDING, BUT NOT LIMITED TO: TREATMENT, HISTORY, FINANCIAL OBLIGATIONS, AND RESPONSIBILITIES TO THE FOLLOWING:

PERSON'S NAME	RELATIONSHIP	PHONE NUMBER
PERSON'S NAME	RELATIONSHIP	PHONE NUMBER

_____ I **DO** GIVE MY PERMISSION TO THE PRACTICE TO ELECTRONICALLY DOWNLOAD MY MEDICATION HISTORY FROM THE INTERNET DATABASE AND UNDERSTAND THAT IT MAY NOT INCLUDE SOME MEDICATIONS.

_____ I **DO NOT** GIVE MY PERMISSION FOR MY MEDICATION HISTORY TO BE ELECTRONICALLY DOWNLOADED

I HAVE REVIEWED THE NOTICE OF PRIVACY PRACTICES OF MANINDER S. GURAM, MD, WHICH EXPLAINS HOW MEDICAL INFORMATION WILL BE PROTECTED, USED AND DISCLOSED. I UNDERSTAND THAT I AM ENTITLED TO RECEIVE A COPY OF THIS DOCUMENT.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE

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TOMBALL GASTROENTEROLOGY ASSOCIATES
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CANCELLATION AND NO-SHOW POLICY

WE STRIVE TO RENDER EXCELLENT MEDICAL CARE TO YOU AND THE REST OF OUR PATIENTS, SO WE UNDERSTAND THAT SITUATIONS ARISE IN WHICH YOU MUST CANCEL YOUR APPOINTMENT. IN ORDER TO PROVIDE ALL OF OUR PATIENTS WITH THE HIGHEST LEVEL OF CARE AND ACCESS, WE REQUEST THAT ALL PATIENTS WHO NEED TO CANCEL THEIR APPOINTMENT PLEASE PROVIDE **24-HOURS NOTICE**. THIS WILL ENABLE US TO BETTER UTILIZE AVAILIABLE APPOINTMENTS FOR OUR PATIENTS.

APPOINTMENT CANCELLATIONS WITH LESS THAN **24-HOURS NOTICE, OR IF THE PATIENT NO-SHOWS** WITHOUT NOTIFICATION, (S)HE WILL BE SUBJECT TO A CANCELLATION FEE. THE CANCELLATION FEES ARE PROVIDED BELOW BASED ON THE TYPE OF APPOINTMENT:

OFFICE VISITS	$50.00
IN-OFFICE PROCEDURES	$100.00
HOSPITAL PROCEDURES	$250.00

THE CANCELLATION AND NO-SHOW FEES ARE THE SOLE RESPONSIBILITY OF THE PATIENT AND MUST BE PAID IN FULL BEFORE THE PATIENT'S NEXT APPOINTMENT.

_____ _____/_____/_____
PATIENT NAME (PLEASE PRINT) PATIENT DATE OF BIRTH

_____ _____/_____/_____
PATIENT SIGNATURE OR PATIENT REPRESENTATIVE TODAY'S DATE

DR. MANINDER S. GURAM
TOMBALL GASTROENTEROLOGY ASSOCIATES
155 SCHOOL ST, STE 250 TOMBALL, TX. 77375
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CURRENT MEDICATIONS:

PLEASE INDICATE WHICH (IF ANY) OF THE FOLLOWING BLOOD THINNERS YOU ARE TAKING:

☐ AGGRENOX ☐ COUMADIN ☐ EFFIENT ☐ ELIQUIS ☐ LOVENOX ☐ PLAVIX ☐ PLETAL
☐ PRADAXA ☐ TICLID ☐ WARFARIN ☐ XARELTO
☐ OTHER _____

PLEASE LIST **ALL** MEDICATIONS YOU ARE CURRENTLY TAKING. ATTACH AN ADDITIONAL SHEET IF NEEDED

MEDICATION NAME			DOSE	FREQUENCY		

ALLERGIES:

DO YOU HAVE ANY KNOWN DRUG ALLERGIES? ☐ YES ☐ NO

PLEASE LIST **ALL** MEDICATIONS YOU ARE ALLERGIC TO AND THE REACTION (ADD ADDT'L SHEET IF NEEDED)

MEDICATION NAME	ALLERGIC REACTION TYPE

TOPICAL ALLERGIES: ☐ IODINE ☐ LATEX ☐ TAPE

ARE YOU ALLERGIC TO IV CONTRAST? ☐ YES ☐ NO

PAST MEDICAL HISTORY:

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MARK THE FOLLOWING CONDITIONS/DISEASES YOU HAVE BEEN TREATED FOR IN THE PAST:

GENERAL MEDICAL:

☐ CANCER - TYPE _____
☐ DIABETES - TYPE _____
☐ HIV/AIDS

HEAD/EYES/EARS/NOSE/THROAT:

☐ HEADACHES
☐ MIGRAINES
☐ HEAD INJURY
☐ HYPERTHYROIDISM
☐ HYPOTHYROIDISM
☐ GLAUCOMA

CARDIOVASCULAR/HEMATOLOGIC:

☐ ANEMIA
☐ BLEEDING DISORDERS
☐ HEART ATTACK
☐ HIGH BLOOD PRESSURE
☐ HIGH CHOLESTEROL
☐ MITRAL VALVE PROLAPSE
☐ MURMUR
☐ PHLEBITIS
☐ POOR CIRCULATION
☐ STROKE
☐ CORONARY ARTERY DISEASE
☐ PACEMAKER/DEFIBRILLATOR

RESPIRATORY:

☐ ASTHMA
☐ BRONCHITIS
☐ EMPHYSEMA/COPD
☐ PNEUMONIA
☐ TUBERCULOSIS

GASTROINTESTINAL:

☐ BOWEL INCONTINENCE
☐ GERD (ACID REFLUX)
☐ GASTROINTESTINAL BLEEDING
☐ CONSTIPATION

MUSCULOSKELTAL:

☐ AMPUTATION
☐ BURSITIS
☐ CARPAL TUNNEL SYNDROME
☐ CHRONIC LOW BACK PAIN
☐ CHRONIC NECK PAIN
☐ CHRONIC JOINT PAIN
☐ FIBROMYALGIA
☐ JOINT INJURY
☐ OSTEOARTHRITIS
☐ OSTEOPOROSIS
☐ PHANTOM LIMB PAIN
☐ RHEUMATOID ARTHRITIS
☐ TENNIS ELBOW
☐ VERTEBRAL COMPRESSION FRACTURE

GENITOURINARY/NEPHROLOGY:

☐ BLADDER INFECTION(S)
☐ DIALYSIS
☐ KIDNEY INFECTION(S)
☐ KIDNEY STONES
☐ URINARY INCONTINENCE

HEPATIC:

☐ HEPATITIS A (ACTIVE/INACTIVE/UNSURE)
☐ HEPATITIS B (ACTIVE/INACTIVE/UNSURE)
☐ HEPATITIS C (ACTIVE/INACTIVE/UNSURE)

NEUROPSYCHOLOGICAL:

☐ ALCOHOL ABUSE
☐ ALZHEIMER'S DISEASE
☐ BIPOLAR DISORDER
☐ DEPRESSION
☐ EPILEPSY
☐ PRESCRIPTION DRUG AB USE
☐ MULTIPLE SCLEROSIS
☐ PARALYSIS
☐ PERIPHERAL NEUROPATHY
☐ SCHIZOPHRENIA
☐ SEIZURES
☐ REFLEX SYMPATHETIC DYSTROPHY/CRPS
☐ OTHER DIAGNOSED CONDS:

_____
_____
_____
_____

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PAST SURGICAL HISTORY:

PLEASE INDICATE ANY SURGICAL PROCEDURES YOU HAVE HAD DONE IN THE PAST, INCLUDING DATE, TYPE, AND ANY PERTINENT DETAILS.

ABDOMINAL SURGERIES:

- ☐ GALLBLADDER REMOVAL _____
- ☐ APPENDECTOMY _____
- ☐ OTHER _____

FEMALE SURGERIES:

- ☐ CAESAREAN SECTION _____
- ☐ HYSTERECTOMY _____
- ☐ LAPAROSCOPY _____
- ☐ OVARIAN _____
- ☐ OTHER _____

HEART SURGERIES:

- ☐ VALVE REPLACEMENT _____
- ☐ ANEURYSM REPAIR _____
- ☐ STENT PLACEMENT _____
- ☐ OTHER _____

JOINT SURGERIES:

- ☐ SHOULDER _____
- ☐ HIP _____
- ☐ KNEE _____

SPINE/BACK SURGERIES:

- ☐ DISECTOMY (LEVELS) _____
- ☐ LAMINECTOMY _____
- ☐ SPINAL FUSION (LEVELS) _____

OTHER COMMON SURGERIES:

- ☐ HEMORRHOID SURGERY _____
- ☐ HERNIA REPAIR _____
- ☐ THYROIDECTOMY _____
- ☐ TONSILLECTOMY _____
- ☐ VASCULAR SURGERY _____

PLEASE LIST ANY OTHER SURGERIES AND DATES (ATTACH ADDT'L SHEET IF NEEDED):

☐ I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE

DIAGNOSTIC TESTS AND IMAGING:

MARK ALL OF THE FOLLOWING TESTS YOU HAVE HAD THAT ARE RELATED TO YOUR CURRENT COMPLAINTS:

☐ MRI OF THE _____ DATE: _____ FACILITY: _____
☐ X-RAY OF THE _____ DATE: _____ FACILITY: _____
☐ CT SCAN OF THE _____ DATE: _____ FACIILITY: _____
☐ EMG/NCV STUDY OF _____ DATE: _____ FACILITY: _____
☐ OTHER DIAGNOSTIC TESTING: _____

☐ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT COMPLAINTS

MARK ALL APPROPRIATE DIAGNOSES AS THEY PERTAIN TO YOUR **BIOLOGICAL MOTHER & FATHER ONLY**

	ARTHRITIS	CANCER	DIABETES	HEADACHES	HEART DISEASE	HIGH BLOOD PRESSURE	HIGH CHOLESTEROL	KIDNEY PROBLEMS	LIVER PROBLEMS	OSTEOPOROSIS	RHEUMATOID ARTHRITIS	SEIZURES	STROKE
MOTHER													
FATHER													

OTHER MEDICAL PROBLEMS: _____

_____ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY

_____ I AM ADOPTED (NO MEDICALY HISTORY AVAILABLE)

SOCIAL HISTORY - PLEASE CIRCLE YOUR ANSWERS BELOW:

ARE YOU CAPABLE OF GETTING PREGNANT? YES NO IF YES, ARE YOU CURRENTLY PREGNANT? YES NO

ALCOHOL USE: DAILY LIMITED USE HISTORY OF ALCOHOLISM CURRENT ALCOHOLISM NEVER DRINKS ALCOHOL

DRINKS ALCOHOL SOCIALLY

TOBACCO USE: CURRENT TOBACCO USER: _____ PACKS PER DAY _____ # YEARS FORMER TOBACCO USER NEVER

ILLEGAL DRUG USE: DENIES ANY ILLEGAL DRUG USE CURRENTLY USES MARIJUANA

CURRENTLY USING ILLEGAL DRUGS: _____

(WHICH ONES)

CURRENTLY USING SOMEONE ELSE'S PRESCRIPTION MEDICATIONS FORMERLY USED ILLEGAL DRUGS (NOT CURRENTLY)

HAVE YOU EVER ABUSED NARCOTIC OR PRESCRIPTION MEDICATIONS? YES NO

IF YES, WHICH ONE(S): _____

PATIENT INTAKE FORM

NAME: _____

DATE: _____

FOR OFFICE PERSONNEL ONLY

WT: _____

BP: _____

P: _____

TEMP: _____

RR: _____

PLEASE CIRCLE IF YOU ARE EXPERIENCING OR HAVE ANY OF THE FOLLOWING:

GENERAL:
FATIGUE
FEVER
UNINTENTIONAL WEIGHT LOSS
UNINTENTIONAL WEIGHT GAIN
DAYTIME SOMNOLENCE
FOGGINESS OF THOUGHT
INABILITY TO COMPLETE TASKS
INSOMNIA

GASTROINTESTINAL:
CONSTIPATION
DIARRHEA
NAUSEA
HEARTBURN
BLOOD IN STOOL

MUSCULOSKELETAL:
NECK PAIN
BACK PAIN
MUSCLE ACHES
JOINT PAIN
JOINT SWELLING

HEENT:
DRY MOUTH
VISUAL CHANGES

GENITOURINARY:
DIFFICULTY URINATING
PAINFUL URINATION
BLOOD IN URINE
INCREASED URINARY FREQUENCY

HEMATOLOGIC:
CLOTTING DIFFICULTIES
EASY BLEEDING
EASY BRUISING

CARDIOVASCULAR:
CHEST PAIN
PALPITATIONS

ENDOCRINE:
HEAT INTOLERANCE
COLD INTOLERANCE
INCREASED THIRST

PSYCHIATRIC:
DEPRESSION
ANXIETY
THOUGHTS OF HARMING ONESELF
THOUGHTS OF HARMING OTHERS
HALLUCINATIONS

PULMONARY:
SNORING
SHORTNESS OF BREATH
COUGH

OBSTRSTUCTIVE SLEEP APNEA
SNORES AT NIGHT
USES CPAP MACHINE
SMOKER
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

NEUROLOGICAL:
GLAUCOMA
DIFFICULTY WALKING
HEADACHES
NUMBNESS
SEIZURES
STROKES
WEAKNESS

OTHER:
MYOCARDIAL INFARCTION
HEART ATTACK
HEART RHYTHM ABNORMALITIES
ABNORMAL EKGs
HISTORY OF CORONARY STENTS
BLOOD THINNING MEDICATION
(ASPIRIN,PLAVIX/CLOPIDOGREL,
HEPARIN/LOVENOX OTHER:
_____)

ANY NEW MEDICATIONS: _____

ANY NEW SURGERIES: _____

ANY CHANGES IN HEALTH: _____

BHRT CHECKLIST FOR MEN

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NAME: _____ DATE: _____

EMAIL: _____

SYMPTOM (PLEASE CHECK MARK)	NEVER	MILD	MODERATE	SEVERE
DECLINE IN GENERAL WELL BEING				
FATIGUE				
JOINT PAIN/MUSCLE ACHES				
EXCESSIVE SWEATING				
SLEEP PROBLEMS				
INCREASED NEED FOR SLEEP				
IRRITABILITY				
NERVOUSNESS				
ANXIETY				
DEPRESSED MOOD				
EXHAUSTION/LACKING VITALITY				
DECLINING MENTAL ABILITY/FOCUS/CONCENTRATION				
FEELING YOU HAVE PASSED YOUR PEAK				
FEELING BURNED OUT/HIT ROCK BOTTOM				
DECREASED MUSCLE STRENGTH				
WEIGHT GAIN/BELLY FAT/INABILITY TO LOSE WEIGHT				
BREAST DEVELOPMENT				
SHRINKING TESTICLES				
RAPID HAIR LOSS				
DECREASE IN BEARD GROWTH				
NEW MIGRAINE HEADACHES				
DECREASED DESIRE/LIBIDO				
DECREASED MORNING ERECTIONS				
DECREASED ABILITY TO PERFORM SEXUALLY				
INFREQUENT OR ABSENT EJACULATIONS				
NO RESULTS FROM E.D. MEDICATIONS				

FAMILY HISTORY	NO	YES
HEART DISEASE		
DIABETES		
OSTEOPOROSIS		
ALZHEIMER'S DISEASE		

BHRT CHECKLIST FOR WOMEN

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NAME: _____ DATE: _____

EMAIL: _____

	NEVER	MILD	MODERATE	SEVERE
DEPRESSIVE MOOD				
FATIGUE				
MEMORY LOSS				
MENTAL CONFUSION				
DECREASED SEX DRIVE/LIBIDO				
SLEEP PROBLEMS				
MOOD CHANGES/IRRITABILITY				
TENSION				
MIGRAINE/SEVERE HEADACHES				
DIFFICULT TO CLIMAX				
BLOATING				
WEIGHT GAIN				
BREAST TENDERNESS				
VAGINAL DRYNESS				
HOT FLASHES				
NIGHT SWEATS				
DRY AND WRINKLED SKIN				
HAIR IS FALLING OUT				
COLD ALL THE TIME				
SWELLING ALL OVER THE BODY				
JOINT PAIN				

FAMILY HISTORY

	NO	YES
HEART DISEASE		
DIABETES		
OSTEOPOROSIS		
ALZHEIMER'S DISEASE		
BREAST CANCER		