Date: __________________________

PERSONAL MEDICAL HISTORY

Name: ____ Birth date: _______________

Telephone number: ____________________________ Mobile: _________________________

Email address: ____

Diagnoses/Past Procedures/Physical Exam (include date/yr):

1. ____
2. ____
3. ____
4. ____
5. ____

Drug sensitivities and allergies:

1. ____
2. ____
3. ____

Family History: important medical problems:

1. ____
2. ____
3. ____
4. ____
5. ____

Date of last physical: _________________ Date of last tetanus shot: ___________________

Date of last dental exam: ______________

Have you ever been told you have one of the following?

Lung disorder	yes	no	Diabetes	yes	no
High blood pressure	yes	no	Arthritis	yes	no
Heart trouble	yes	no	Hepatitis	yes	no
Nervous disorder	yes	no	Malaria	yes	no
Disease or digestive tract disorders	yes	no	Disease of the kidney	yes	no
Any vision of hearing disorders	yes	no	Any form of cancer	yes	no