PERSONAL MEDICAL HISTORY

Name: _____ DOB: _____/_____/_____

Address:_____

Phone:_____/_____-_____ Email:_____

1.Med. Ins. Provider: _____Policy#:_____ Group:_____

Phone: ____/_____-_____ Address:_____

2.Med Ins. Provider: _____Policy#: _____ Group: _____

Phone:____/_____-_____ Address:_____

Emergency contact:_____ Relation:_____

Phone:_____/_____-_____ Email:_____

Primary Physician Name:_____ Phone:____/_____-_____

Recent physical date: _____/_____/_____

Diagnoses/Past Procedures and Surgeries: (include date/yr)

1._____
2._____
3._____
4._____

Medications: Include name, dosage, frequency

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____
5. _____ 9. _____

Drug sensitivities and allergies:

1. _____ 3. _____
2. _____ 4. _____

Date of last dental exam: _____/_____/_____ Date of last tetanus shot: _____/_____/_____

Have you ever been told you had one of the following:

COPD, asthma, lung conditions	yes no	Diabetes	yes no
High blood pressure	yes no	Arthritis	yes no
Heart trouble	yes no	Hepatitis	yes no
Any form of cancer	yes no	Malaria	yes no
Digestive tract disease/disorder	yes no	Kidney disease	yes no
Vision or hearing disorder	yes no	Nervous disorder	yes no
Sleep apnea	yes no	Other:_____	
Advanced Directive attached:	yes no	DNR attached;	yes no