

Personal Medical History Form

(Complete a form for each member of your family.)

Name: _____ **Birthdate:** _____

Address: _____

Home Number: _____ **Mobile:** _____

Primary Physician: _____

Phone number: _____

PRESENT MEDICAL CONDITION:

MEDICATIONS: Include prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

Medication	Dose	Times Per Day

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:

Medication	Reaction or Side Effect

SURGICAL HISTORY (Please list all prior operations, hospital stays and dates):

Operation/Procedure	Date

IMMUNIZATIONS: Please list your most recent immunizations. Include your best estimate of the month and year of each immunization:

Measles ____ **Mumps**____ **Rubella**_____
Tetanus (Td) ____ **Varicella (chicken pox) shot** ____
Other _____

Name of Health Insurance Carrier:

Group #: _____

Agreement or Policy #: _____