Medical History

Last Name First Name MI Sex: Blood Type

Date of Birth Social Security Number Home Phone

Street Address City State Zip

Emergency Contact Names Relationship Daytime Phone Number Evening Phone

Primary Care Physician Specialty Office Phone Number

Other Physicians' Names Specialty Office Phone Number

Health Insurance Type Phone Group No. ID Number

Prescription Medications Dosage Frequency

Where Do You Keep Your Medications?

Any Medicine and/or Food Allergies? Typical Reaction

Chronic Health Problems (*Indicate all with YES or NO)*
High Blood Pressure? Pacemaker? Diabetes? Asthma? Arthritis?

(Indicate all with YES or NO or explain)
Heart Problems:
Seizure Disorders/Strokes:
Other Lung Conditions:
Kidney Problems:
List any Other Conditions:

Have you recently had surgery or any medical procedure? *(YES or NO)*
If so when? Explain:

Do you have any? *(Indicate all with YES or NO)*
Glasses? Contacts? Dentures? Prosthesis? Hearing Aids?

Do you have a portable order or living will? Where located?
Do you have a medical power of attorney? Where located?
Attorney's Name? Office Phone Number

Are you an organ donor? *(YES or NO*) Preferred Hospital:

List all over the counter drugs, vitamins and herbals that you currently take along with dosages and frequencies: