MEDICAL HISTORY FORMS

Last Name _____ First Name _____ DOB _____

Marital Status _____ Religion _____ ☐ Male ☐ Female

Address _____ State _____ Zip Code _____

Phone (Home) _____ (Work) _____ (Cell) _____

ALLERGIES to Medications: ☐ YES ☐ NO If Yes, list allergies _____

ALLERGIES to Foods, Man-Made Materials, etc.: ☐ YES ☐ NO If Yes, list allergies _____

Insurance Co. _____ Policy No. _____

Emergency Contact: Name _____ Relationship _____

Phone (Home) _____ (Work) _____ (Cell) _____

Who Do You Grant Permission to Speak on Your Behalf? (If Different Than Emergency Contact)

Emergency Contact: Name _____ Relationship _____

Phone (Home) _____ (Work) _____ (Cell) _____

Physicians (Health Care Providers(s)):

Name _____ Specialty _____ Phone _____

Name _____ Specialty _____ Phone _____

Present Medical History: _____

Past Medical History (including place and dates of hospitalizations): _____

Medications: (Prescription, Supplements, Vitamins, Herbal Supplements, Over-the-Counter)

Pharmacy Name & Phone Number _____

Name:	Dose (# milligrams, etc.)	No. of Times Day:	Route (By mouth, injection etc):