Personal Medical History

Name: ______________________________ Birthdate: ______________________________

Physician: ______________________________ Telephone numbers: ______________________________

______________________________ ______________________________

Dentist: ______________________________ ______________________________

Eye doctor: ______________________________ ______________________________

Other: ______________________________ ______________________________

______________________________ ______________________________

Your current medical condition: ____

____

List prescription and non-prescription medications you are taking: ______________________________

____

____

Drug sensitivity and allergies (describe): ____

____

____

Name of health insurance carrier: ______________

____

____

Group no.: ______________________________

Agreement no.: ______________________________

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

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

Disease or disorder of the blood? (describe) ____________

Any physical defect or deformity? (describe) ____________

Any vision or hearing disorders? (describe) ____________

Any life-threatening conditions? (describe) ____________

Any contagious disorders? (describe) ________________

(see next page)

Personal Medical History

Have you been treated by a physician or been disabled or hospitalized during the last year? (describe)

____

____

____

____

____

Have you had or been advised to have a surgical operation within the last five years? (describe)

____

____

____

____

____

Date of last physical: ____

Date of last tetanus shot: ____

Family history — list important medical problems of your parents: ______________________________

Mother: ____

____

Father: ____

____

Any other special medical information: ____

____

____

____

____

____

____