

Personal Medical History

Page 1

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?

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

Page 2

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: _____