DO NOT WRITE ON THIS FORM. USE IT TO MAKE COPIES.

Personal Medical History

(Please complete a form for each member of your family.)

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)

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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:_____

_____

_____

_____

_____

_____

_____