Medical History

Date Updated
/ /

Patient Information		Preferred Language	
Name	DOB	Gender	Sex
Address		Phone	
Emergency Contact #1	Check here if medical proxy ☐		
Name	Relationship	Phone	
Emergency Contact #2			
Name	Relationship	Phone	
Emergency Contact #3			
Name	Relationship	Phone	

Insurance Information	
Insurance Provider	Policy Number

Personal History (*Check all that apply*)

- ☐ No known medical conditions
- ☐ Allergies, specify:
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Cancer, specify:
- ☐ Congestive heart failure
- ☐ COPD / Emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy / Seizures
- ☐ GERD (Acid Reflux)
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack / Heart Disease
- ☐ High Blood Pressure (Hypertension)
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ Kidney Disease / Kidney Stones
- ☐ Liver Disease / Hepatitis
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pregnant or could be pregnant
- ☐ Stroke
- ☐ Substance Use
- ☐ Thyroid Disease
- ☐ Tuberculosis

Other medical issues:

Treatments/Medications

Name(s)	Dosage(s)	Frequency	Purpose	Note(s)

Treatments/Medications				
Name(s)	**Dosage(s)**	**Frequency**	**Purpose**	**Note(s)**

Dietary restrictions:	**Allergies:**

Family History (*Check all that apply*)

☐ No known family history of medical conditions	☐ Stroke
☐ Cancer	☐ Thyroid Disease
☐ Diabetes	☐ Kidney Disease
☐ Heart Disease	☐ Mental Health Conditions (Depression, Anxiety, etc.)
☐ High Blood Pressure	☐ Autoimmune Diseases
☐ High Cholesterol	☐ Other, specify:

Name of Primary Care Provider (PCP): **Phone number and address of PCP:**	**Additional health information:**

Surgeries/Procedures (with dates):	**Additional information in envelope:** ☐ Advanced Directive ☐ Do Not Resuscitate (DNR) ☐ Clinician Orders for Life-Sustaining Treatment (COLST) ☐ Organ Donor

Name of pharmacy:

Phone number of pharmacy:

Address of pharmacy: