



MEDICAL HISTORY FORM

General Information

Clients Name: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home: (____) _____ Work: (____) _____ Cell: (____) _____

E-mail address: _____ SS# _____ Date of Birth: _____

Height: _____ Weight: _____ Are you a veteran? ☐ Yes ☐ No

Are you currently employed? ☐ Yes ☐ No

If yes, what is the name of employer? _____

What was your last date of employment? _____

Emergency Contact: _____ Relationship: _____

Home: (____) _____ Work: (____) _____ Cell: (____) _____

If the above person is unavailable, please notify: _____ Relationship: _____

Insurance Information

Please indicate if you have any insurance or if you are covered under someone else's insurance.

Company Name: _____ Policy Number: _____

Contact Number (if applicable): _____

If covered by someone else's insurance: _____

Hospitalization

Are you currently under medical care for any reasons? If yes, please explain: _____

List all times you have been admitted to a hospital (starting with most recent)

Reason Hospitalized	Year	Hospital	Doctor
_____	_____	_____	_____
_____	_____	_____	_____

List All Operations

Operation Performed	Year	Hospital	Doctor
_____	_____	_____	_____
_____	_____	_____	_____

Please list all prescription, over-the-counter, and natural medications you are taking. Use a separate sheet if necessary.

Medication Name	Dosage	Frequency	Side Effects (known & potential)	Reason for Taking

Allergies

Include medicines, foods, animals, insect bites and stings, and environment (dust, pollen, etc.) NONE

Allergy	Reaction	Medication Required (if any)

Have you ever had the following conditions below: (please check one)?

High Blood Pressure	_____	Kidney Disease	_____	Asthma	_____
Stroke	_____	Bleeding Tendencies	_____	Tuberculosis	_____
Cancer	_____	Seizures	_____	Colitis	_____
Emphysema	_____	Heart Disease	_____	Anemia	_____
Ulcers	_____	Sugar Diabetes	_____	Gout	_____
Mental Illness	_____	Other	_____		

Client Print Name: _____ Date: _____

Client Signature: _____