

**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)

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

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: \_\_\_\_\_

---

---

---

---

---

---

---