MEDICAL INFORMATION

Form Date : _____

Name: _____ Date Of Birth: ___/ ___/ ___
Street: _____ Male: ____ Female: ____
City: _____ Doctor #1: _____
State: _____ ZIP: _____ Doctor #2: _____
Social Security No.: _____-_____-_____ Insurance ID No.:_____
Are you allergic to any medications, (yes __ no __) if yes. what are they? _____

Are you taking any Over The Counter Drugs (i.e. aspirin, vitamins), (yes __ no __) if yes, what are they? _____

If you are taking any prescription drugs please list them below:

NAME	STRENGTH(MG)	FREQUENCY	TAKEN FOR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any past medical history of any of the following:

	YES	NO		YES	NO
Diabetes:	____	____	Congestive Heart Failure:	____	____
Emphysema:	____	____	High Blood Pressure:	____	____
Asthma:	____	____	Heart Problems:	____	____
COPD:	____	____	Stroke:	____	____
Seizures:	____	____	Eye Problems:	____	____

Other: _____
Were you hospitalized in the past year? (yes __ no __) If yes, where and why:

_____
Have you had any surgeries in the past 5 years? (yes __ no __) If yes, where and why:

_____

Contact Person: _____ Relationship:_____

Phone No.: _____

Any Implants(Pacemaker, Glass Eye)? (yes__no__) Describe:_____
