PERSONAL HEALTH HISTORY

INSURANCE INFORMATION

Primary insurance:_____ **Subscriber's name:** _____

DOB:_____/_____/_____ **Address:** _____

Policy #:_____ **Group #:** _____

Customer service phone #: (_____) _____-_____

EMERGENCY CONTACT

Name:_____ **Phone #:** (_____)_____-_____

Relationship: _____

MEDICAL CONDITIONS

CURRENT MEDICATIONS

Medication (include prescriptions/over-the-counter)	**Dose**	**Strength**

ALLERGIES

Allergy	**Reaction**

MAJOR MEDICAL PROCEDURES

Previous hospitalizations, surgeries	**Date, location, procedure** (if applicable)

FAMILY HISTORY

Please indicate if any family members (parents, siblings, grandparents) have any major medical conditions. Use the following abbreviations to illustrate who: **M** = Mother, **F** = Father, **S** = Sister, **B** = Brother, **MGM** = Maternal Grandmother, **MGF** = Maternal Grandfather, **PGM** = Paternal Grandmother, **PGF** = Paternal Grandfather, **O** = **Other**

Yes	Who	Condition	Yes	Who	Condition

ADDITIONAL NOTES
