



In association with SMDC Health System

PERSONAL MEDICAL HISTORY

PLEASE COMPLETE A FORM FOR EACH FAMILY MEMBER.

Name:	Birthdate:
Address:	Phone numbers:

Physician Information:	Name	Phone	Fax	Date of first visit
Regular Physician				
Eye doctor				
Dentist				
Specialist/Other				

List Known Allergies

Food: _____

Medication: _____

Medication Information (prescription and non-prescription)			
Drug name	Date started	Dosage	Frequency

Have you ever been told you had any of the following (circle all that apply):

- | | | |
|---------------------|-------------------------------------|--------------------------------------|
| Lung disorder | Diabetes | Any form of cancer |
| High blood pressure | Arthritis | Disease of the kidney |
| Heart trouble | Hepatitis | Malaria |
| Nervous disorder | Disease/disorder of digestive tract | Any contagious disorders (describe): |

Disease/disorder of the blood (describe): _____

Any physical defect or deformity (describe): _____

Any vision or hearing disorders (describe): _____

Any life-threatening conditions (describe): _____

PERSONAL MEDICAL HISTORY

PAGE 2

Describe your current medical condition:

Have you been seen by a physician or been hospitalized in the last year (describe)?

Have you had or been advised to have surgery within the last five years (describe)?

Date of last physical:

Date of last tetanus:

Family History (list health history and conditions of family members)

Mother:

Father:

Siblings:

Maternal grandmother:

Maternal grandfather:

Paternal grandmother:

Paternal grandfather:

Your next of kin

Name

Address

Phone

Relationship to you

Health Insurance Information

Name of Carrier:

Account/policy number:
