Name:_____ **Date of Birth:**_____

Personal Medical History

Name: _____ Birthdate: _____

Address: _____ Telephone numbers: _____

_____ _____

Physician: _____ _____

Eye doctor: _____ _____

Other: _____ email: _____

_____ _____

Your current medical condition: _____

_____

List prescription and non-prescription medications you are taking: _____

_____

_____

Drug sensitivity and allergies (describe): _____

_____

_____

Have you been treated by a physician or been disabled or hospitalized during the last year? (describe)

_____

_____

_____

_____

_____

_____

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)

_____ _____

Patient Signature/Date M.D. Signature/Date