

Medical history form

Last name, first name:		Date of birth:	
Health insurance:		Phone:	
Pre-existing conditions:			
Operations:			
Allergies/intolerances:			
Immunization status (please include immunization record):			
Medications (name/active ingredient)	Morning	Midday	Evening
Height:	Weight:	☐ Alcohol	☐ Nicotine ☐ Drugs
Family history (are chronic conditions such as diabetes/high blood pressure/cancer known?):			
Social history Occupation:		Marital status:	Children:
Receiving in-home care? (if so, please provide level of care)			
Do you have a living-will? ☐ Yes ☐ No		Do you have a health care power of attorney? ☐ Yes ☐ No	
Year of last check-up examination:			
Name of last primary care physician:			