WE WHO CARE

MEDICAL HISTORY

Section 1 - Physician(s), Conditions, Allergies and Implanted Devices

Patient Information:

First: _____ Middle: _____ Last: _____

DOB: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Physician Information:

Primary Physician: _____ Specialty: _____

Phone Number: _____

Additional Physician: _____ Specialty: _____

Phone Number: _____

Additional Physician: _____ Specialty: _____

Phone Number: _____

Please complete the information below **only with conditions relevant to immediate emergency treatment**

Known Conditions: 1. _____ 2. _____

3. _____ 4. _____

Drug Allergies: 1. _____ 2. _____

3. _____ 4. _____

Other Allergies: 1. _____ 2. _____

3. _____ 4. _____

Implanted Medical Devices:
Include manufacturer, model & serial Number

1. _____

2. _____

3. _____

WE WHO CARE

MEDICAL HISTORY

Section 2 - Medications, Surgeries, Family Illnesses and Insurance

Medications:
Include Daily Dosage

	Medication Name		Dosage
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	
6.		6.	
7.		7.	
8.		8.	
9.		9.	
10.		10.	

Previous Surgeries and Procedures:

Major Family Illnesses:

Insurance Name:

Phone:

Policy / Group #:

Additional Information: