Adult Medical History Form

_____ _____

Name *Date*

Please complete all pages

Your answers on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you**!

PRESENT HEALTH CONCERNS: _____

_____

_____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs

Medication	Dose	Times/Day

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:

Medication/Food/Other Agent	Reaction or Side Effect

Note: This form is intended for practice purposes only. It is not an official health form and is not intended for medical use.

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any previous medical problems (with approximate date of illness or diagnosis):

Illness	Date of Diagnosis

SURGICAL HISTORY: (Please list all prior operations and dates)

Operation	Date

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Health Insurance Information Form

[Please fill out one form for each member of the family that has insurance]

Name: _____

Date of Birth: _____ Gender: _____Male _____Female

Home Address: _____

Home Phone: _____

Work Phone: _____ Cell Phone: _____

Email Address: _____

INSURANCE INFORMATION

Insurance Carrier: _____

Policy Number: _____

Group Number: _____

Insurance Address: _____

Insurance Phone Number: _____

Name of Policy Holder (other than self): _____

Address of Policy Holder: _____

In Case of Emergency (ICE contact information)

Name of Person to Notify: _____

Relationship to You:_____

Phone Number: _____

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