Medical History Form

Today's Date: _____ Date of Birth: _____
First Name: _____ Middle Initial: _____ Last Name: _____
Primary Care Provider: _____ Office Phone: (____)___-_____
Primary Care Address:_____
City: _____ State: _____ Zip:_____
Date of Last Visit:_____ Purpose for Last Visit:_____

Current Medications:

Name of Medication	Dose

Allergies:

Medication Allergies	Other Allergies

Major Medical Issues: (Check all that apply):

	High Blood Pressure	☐	Heart Disease	☐	Diabetes/Pre-Diabetes ☐
	Asthma	☐	High Cholesterol	☐	Obesity ☐
	Other: _____				

Surgeries/Hospitalizations:

Year	Reason	Hospital

RN Signature: _____