MEDICAL HISTORY

Date:	Address:
Family name:	
Surname:	
Phone #:	
Cel:	
Email:	

Marital status

Single ○ Separated ○
Married ○ Widow ○
Divorced ○

Date of birth: ____ / ____ / ____ (D/M/Y)

Age: | Sex: F ☐ M ☐

Medicare # :

Hight: | Weight:

Occupation:	Employer:	Phone # (work):

Primary care physician:	Phone #:

IN CASE OF EMERGENCY

Person to contact in case of emergency:	Phone # res.:
	Cel #:
Relationship to the patient:	Phone # work::

Check Yes or No for each of these questions, and give details for any 'Yes' answers on page 2.

Have you ever had or do you now have:

	Yes	No		Yes	No
Tuberculosis			Jaundice or hepatitis		
Asthma			Hernya		
Allergies			Hemmorrhoids or bloody stools		
Chronic Bronchitis			Skin disease, acne, eczema, psoriasis..		
Lung disorder			Frequent or painful urination		
Sinusitis			Diabetes		
Hay Fever			Hypoglycemya		
trouble			Kidney problems		
Thyroid			Adrenal problems		
Eye disorder or trouble			Suexualy transmitted disease		
Hearing loss			Overweight		
Muscular troubles			Anerexia or boulimia		
Arthritis			Tumor, growth, cyst or cancer		
Rheumatism			Dizziness or fainting spells		
Bursitis			Severe headaches or migraines		
Back pain			Memory loss		
Numbness			Paralysis		
Swollen or painful joints			Convulsions or épilepsy		
Knee trouble			Méningitis, encéphalitis or other neurological trouble		
Broken bone(s)			Palpitations, cardiac trouble		
Frequent indigestion or reflux			High blood pressure		
Stomack, liver, intestinal trouble, or ulcer			Low blood pressure		
Gall bladder trouble of gallstones			Anxiéty or panic attacks		
Rectal or intestinal trouble			Depression or other mental condition		
Gynecological problems			Attempted suicide		
Miscarriage			Head trauma		
Abortion			Transplant		
Infertility			Alcool or drugs abuse		
Contagious disease			AIDS		
Surgeries			Other _____		

MEDICAL HISTORY... 2

Family name:	Surname:

Describe below any 'Yes' answers from page 1 concerning your health condition, by mentioning the question #, the health problem and all pertinent information or dates of treatment for each condition.

No:	Health problem:
Details:	

No:	Health problem:
Details:	

No:	Health problem:
Details:	

No:	Health problem:
Details:	

No:	Health problem:
Details:	

Make extra copies of this page if needed.

Medical History... 3

Family name:	Surname:

	Medical conditions	Deceased - Cause
Father		
Mother		
Siblings		
Children		

Write down all vaccinations received to this day, including approximative date:

Vaccine	Date	Vaccine	Date

MEDICATION

Medication	Dosage	Purpose

I certify that the information on this form is true and complete to the best of my knowledge, and I further understand that I may be requested to provide more detailed medical documentation regarding issues within my medical history.

Signature:	Date: