Medical History Form

(Please print this form and keep it in a location known to all family members)

Name:____

Address:____

____

DOB: _____/_____/________ Weight: _______lbs

SSN#: __ __ __ - __ __ - __ __ __ __ Medicare #:__ __ __ - __ __ - __ __ __ __ - __

Medicaid #: __ __ __ __ __ __ __ __ __ __

Insurance: (Company) _______________________ group #:___________id#:_______________________

Insurance: (Company) _______________________ group #:___________id#:_______________________

Family Doctor's Name:_________________________ Phone#: _______________

Medical Problems (ie. Heart attack, diabetes, stroke, etc.): ______________________,

__________________, _____________________, _____________________, ____________________,

____________________, ___________________, _____________________, ____________________

Medications taken every day and dosage (ie. Lasix 60mg): ____________________,

_________________, ________________, _______________, _______________________,

_________________, ________________, _______________, _______________________

Medications that you are allergic to (ie. Penicillin): ____________, ______________,

_______________, ___________________, _____________________, ________________

This form should be presented to your doctor or EMS provider at the time of treatment. You should also update this form any time that your medications or medical condition changes.