About Your Medical History

What is your full legal name?

What is your date of birth?

What is your Social Security number?

Your Doctors

Doctor's Name	Address	Telephone Number	Condition Treated

Nearest Hospital

Name	Address	Telephone

Do you have a living will and/or a durable health-care power of attorney? If so, where is the document located?

What is your blood type?

Are you allergic to any medications? If so, list them.

Do you suffer from any chronic illness(es): i.e., high blood pressure, diabetes, etc.?

Are you currently taking medication? If so, list.

Since (Date)	Name of Drug/Medicine	Drug/Medicine Is Taken for Which Ailment?	Dosage and Times Medicine Is to Be Taken	Prescribing Physician

What is the name and telephone number of your health-care provider (medical insurance)?

What is the policy (or certificate) number?

Where is the policy (certificate) located?

About Your Medical History

Allergies

Allergy	Symptoms of Reaction	Method Used to Relieve Allergic Reaction

Immunization History

Date	Immunized Against (e.g.: Tetanus, German Measles, etc.)

Indicate which of the following you have had or have at present. Circle "yes" or "no" for each item. **If you circled "yes" for any of the items, list the dates and details on the "Notes, Thoughts, and Attachments" pages at the back of this section.**

Heart failure	Yes	No
Heart disease or attack	Yes	No
Angina pectoris	Yes	No
Congenital heart disease	Yes	No
Heart murmur	Yes	No
High blood pressure	Yes	No
Arteriosclerosis	Yes	No
Mitral valve prolapse	Yes	No
Artificial heart valve	Yes	No
Heart pacemaker	Yes	No
Heart surgery	Yes	No
Rheumatic fever	Yes	No
Arthritis	Yes	No
Rheumatism	Yes	No
Cortisone medicine	Yes	No
Drug or alcohol addiction	Yes	No
Stroke	Yes	No
Artificial joints (hip, knee, etc.)	Yes	No
Kidney trouble	Yes	No
Ulcers	Yes	No
Diabetes	Yes	No
Thyroid problems	Yes	No
Glaucoma	Yes	No
Cancer	Yes	No
Emphysema	Yes	No
Pneumonia	Yes	No
Chronic cough	Yes	No
Tuberculosis	Yes	No

About Your Medical History

Asthma	Yes	No
Hay fever	Yes	No
Sinus trouble	Yes	No
Radiation therapy	Yes	No
Chemotherapy	Yes	No
Hepatitis A (infectious)	Yes	No
Hepatitis B (serum)	Yes	No
Venereal disease	Yes	No
AIDS	Yes	No
HIV positive	Yes	No
Blood transfusions	Yes	No
Hemophilia	Yes	No
Anemia	Yes	No
Sickle cell disease	Yes	No
Liver disease	Yes	No
Yellow jaundice	Yes	No
Epilepsy or seizures	Yes	No
Fainting or dizzy spells	Yes	No
Nervous disorders	Yes	No
Tumors	Yes	No
Developmental disability	Yes	No
Mental illness	Yes	No
Do you have or have you had any disease, condition or problem not listed here?	Yes	No

For women only:

Are you pregnant? If yes, what month are you due?	Yes	No
Are you nursing?	Yes	No
Are you taking birth control pills?	Yes	No
Are you on any special diet?	Yes	No
Have you gained or lost more than 10 pounds in the past year?	Yes	No

About Your Parents', Grandparents', and Siblings' Medical History

Name	Relationship	Date of Birth	Current State of Health	Date of Death and Age at Death	Cause of Death	Other Medical Information*
	Father					
	Mother					
	Maternal grandfather					
	Maternal grandmother					
	Paternal grandfather					
	Paternal grandmother					
	Brother					
	Sister					

*e.g., cancer, heart disease, diabetes, Alzheimer's disease, drug abuse, mental illness, etc.

Are there any other medical facts about your parents, grandparents, and siblings (e.g., possible hereditary or congenital defects, problems, or abnormalities) that should be included?

Name and Relationship	Medical Fact

About Your Spouse's Medical History

What is your spouse's full legal name?

What is your spouse's date of birth?

What is your spouse's Social Security number?

Your Spouse's Doctors

Doctor's Name	Address	Telephone Number	Condition Treated

Nearest Hospital

Name	Address	Telephone

Does your spouse have a living will and/or a durable health-care power of attorney? If so, where is the document located?

What is your spouse's blood type?

Is your spouse allergic to any medications? If so, list them.

Does your spouse suffer from any chronic illness(es): i.e., high blood pressure, diabetes, etc.?

Is your spouse currently taking medication? If so, list.

Since (Date)	Name of Drug/Medicine	Drug/Medicine Is Taken for Which Ailment?	Dosage and Times Medicine Is to Be Taken	Prescribing Physician

What is the name and telephone number of your spouse's health-care provider (medical insurance)?

What is the policy (or certificate) number?

Where is the policy (certificate) located?

About Your Spouse's Medical History

Allergies

Allergy	Symptoms of Reaction	Method Used to Relieve Allergic Reaction

Immunization History

Date	Immunized Against (e.g.: Tetanus, German Measles, etc.)

Indicate which of the following your spouse has had or has at present. Circle "yes" or "no" for each item. **If you circled "yes" for any of the items, list the dates and details on the "Notes, Thoughts, and Attachments" pages at the back of this section.**

Heart failure	Yes	No
Heart disease or attack	Yes	No
Angina pectoris	Yes	No
Congenital heart disease	Yes	No
Heart murmur	Yes	No
High blood pressure	Yes	No
Arteriosclerosis	Yes	No
Mitral valve prolapse	Yes	No
Artificial heart valve	Yes	No
Heart pacemaker	Yes	No
Heart surgery	Yes	No
Rheumatic fever	Yes	No
Arthritis	Yes	No
Rheumatism	Yes	No
Cortisone medicine	Yes	No
Drug or alcohol addiction	Yes	No
Stroke	Yes	No
Artificial joints (hip, knee, etc.)	Yes	No
Kidney trouble	Yes	No
Ulcers	Yes	No
Diabetes	Yes	No
Thyroid problems	Yes	No
Glaucoma	Yes	No
Cancer	Yes	No
Emphysema	Yes	No
Pneumonia	Yes	No
Chronic cough	Yes	No
Tuberculosis	Yes	No

About Your Spouse's Medical History

Asthma	Yes	No
Hay fever	Yes	No
Sinus trouble	Yes	No
Radiation therapy	Yes	No
Chemotherapy	Yes	No
Hepatitis A (infectious)	Yes	No
Hepatitis B (serum)	Yes	No
Venereal disease	Yes	No
AIDS	Yes	No
HIV positive	Yes	No
Blood transfusions	Yes	No
Hemophilia	Yes	No
Anemia	Yes	No
Sickle cell disease	Yes	No
Liver disease	Yes	No
Yellow jaundice	Yes	No
Epilepsy or seizures	Yes	No
Fainting or dizzy spells	Yes	No
Nervous disorders	Yes	No
Tumors	Yes	No
Developmental disability	Yes	No
Mental illness	Yes	No
Do you have or have you had any disease, condition or problem not listed here?	Yes	No
For women only:		
Is your spouse pregnant? If yes, what month is your spouse due?	Yes	No
Is your spouse nursing?	Yes	No
Is your spouse taking birth control pills?	Yes	No
Is your spouse on any special diet?	Yes	No
Has your spouse gained or lost more than 10 pounds in the past year?	Yes	No

About Your Spouse's Parents', Grandparents', and Siblings' Medical History

Name	Relationship	Date of Birth	Current State of Health	Date of Death and Age at Death	Cause of Death	Other Medical Information*
	Father					
	Mother					
	Maternal grandfather					
	Maternal grandmother					
	Paternal grandfather					
	Paternal grandmother					
	Brother					
	Sister					

*e.g., cancer, heart disease, diabetes, Alzheimer's disease, drug abuse, mental illness, etc.

Are there any other medical facts about your spouse's parents, grandparents, and siblings (e.g., possible hereditary or congenital defects, problems, or abnormalities) that should be included?

Name and Relationship	Medical Fact

Date of Entry	***Notes, Thoughts, and Attachments***

About Your Child's Medical History

What is your child's full legal name?

What is your child's date of birth?

What is your child's Social Security number?

Your Child's Doctors

Doctor's Name	Address	Telephone Number	Condition Treated

Nearest Hospital

Name	Address	Telephone

Do you have a durable health-care power of attorney (medical consent) for your child? If so, where is the document located?

What is your child's blood type?

Is your child allergic to any medications? If so, list them.

Does your child suffer from any chronic illness(es): i.e., high blood pressure, diabetes, etc.?

Is your child currently taking medication? If so, list.

Since (Date)	Name of Drug/Medicine	Drug/Medicine Is Taken for Which Ailment?	Dosage and Times Medicine Is to Be Taken	Prescribing Physician

What is the name and telephone number of the health-care provider (medical insurance) that the child is covered under?

Who is listed as the insured?

What is the policy (or certificate) number?

Where is the policy (certificate) located?

About Your Child's Medical History

Allergies

Allergy	Symptoms of Reaction	Method Used to Relieve Allergic Reaction

Immunization History

Date	Immunized Against (e.g.: Tetanus, German Measles, etc.)

Indicate which of the following your child had or has at present. Circle "yes" or "no" for each item. **If you circled "yes" for any of the items, list the dates and details on the "Notes, Thoughts, and Attachments" pages at the back of this section.**

Heart failure	Yes	No
Heart disease or attack	Yes	No
Angina pectoris	Yes	No
Congenital heart disease	Yes	No
Heart murmur	Yes	No
High blood pressure	Yes	No
Arteriosclerosis	Yes	No
Mitral valve prolapse	Yes	No
Artificial heart valve	Yes	No
Heart pacemaker	Yes	No
Heart surgery	Yes	No
Rheumatic fever	Yes	No
Arthritis	Yes	No
Rheumatism	Yes	No
Cortisone medicine	Yes	No
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Artificial joints (hip, knee, etc.)	Yes	No
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Ulcers	Yes	No
Diabetes	Yes	No
Thyroid problems	Yes	No
Glaucoma	Yes	No
Cancer	Yes	No
Emphysema	Yes	No
Pneumonia	Yes	No
Chronic cough	Yes	No
Tuberculosis	Yes	No

About Your Child's Medical History

Asthma	Yes	No
Hay fever	Yes	No
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Radiation therapy	Yes	No
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HIV positive	Yes	No
Blood transfusions	Yes	No
Hemophilia	Yes	No
Anemia	Yes	No
Sickle cell disease	Yes	No
Liver disease	Yes	No
Yellow jaundice	Yes	No
Epilepsy or seizures	Yes	No
Fainting or dizzy spells	Yes	No
Nervous disorders	Yes	No
Tumors	Yes	No
Developmental disability	Yes	No
Mental illness	Yes	No
Does your child have or has he/she had any disease, condition or problem not listed here?	Yes	No
Is your child on any special diet?	Yes	No
Has your child gained or lost more than 10 pounds in the past year?	Yes	No

Describe any special information, habits, personality traits, or behaviors that relate to your child.

Date of Entry	***Notes, Thoughts, and Attachments***

About Your Child's Medical History

What is your child's full legal name?

What is your child's date of birth?

What is your child's Social Security number?

Your Child's Doctors

Doctor's Name	Address	Telephone Number	Condition Treated

Nearest Hospital

Name	Address	Telephone

Do you have a durable health-care power of attorney (medical consent) for your child? If so, where is the document located?

What is your child's blood type?

Is your child allergic to any medications? If so, list them.

Does your child suffer from any chronic illness(es): i.e., high blood pressure, diabetes, etc.?

Is your child currently taking medication? If so, list.

Since (Date)	Name of Drug/Medicine	Drug/Medicine Is Taken for Which Ailment?	Dosage and Times Medicine Is to Be Taken	Prescribing Physician

What is the name and telephone number of the health-care provider (medical insurance) that the child is covered under?

Who is listed as the insured?

What is the policy (or certificate) number?

Where is the policy (certificate) located?

About Your Child's Medical History

Allergies

Allergy	Symptoms of Reaction	Method Used to Relieve Allergic Reaction

Immunization History

Date	Immunized Against (e.g.: Tetanus, German Measles, etc.)

Indicate which of the following your child had or has at present. Circle "yes" or "no" for each item. **If you circled "yes" for any of the items, list the dates and details on the "Notes, Thoughts, and Attachments" pages at the back of this section.**

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Rheumatism	Yes	No
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Ulcers	Yes	No
Diabetes	Yes	No
Thyroid problems	Yes	No
Glaucoma	Yes	No
Cancer	Yes	No
Emphysema	Yes	No
Pneumonia	Yes	No
Chronic cough	Yes	No
Tuberculosis	Yes	No

About Your Child's Medical History

Asthma	Yes	No
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Venereal disease	Yes	No
AIDS	Yes	No
HIV positive	Yes	No
Blood transfusions	Yes	No
Hemophilia	Yes	No
Anemia	Yes	No
Sickle cell disease	Yes	No
Liver disease	Yes	No
Yellow jaundice	Yes	No
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Fainting or dizzy spells	Yes	No
Nervous disorders	Yes	No
Tumors	Yes	No
Developmental disability	Yes	No
Mental illness	Yes	No
Does your child have or has he/she had any disease, condition or problem not listed here?	Yes	No
Is your child on any special diet?	Yes	No
Has your child gained or lost more than 10 pounds in the past year?	Yes	No

Describe any special information, habits, personality traits, or behaviors that relate to your child.

Date of Entry	***Notes, Thoughts, and Attachments***