Medical History

Name: _____
Address: _____
Phone Number: _____
Healthcare Proxy: _____

Full name
Date of birth _____
Blood type _____
Allergies _____
Primary care physician (name and phone)

_____
Other Drs. currently providing care (name and phone)

_____
_____
_____
Last flu shot _____
COVID vaccination type and date

_____
Existing health problems

_____
Past surgeries (with dates)

_____
_____
Past hospitalizations (dates and reasons)

_____
_____
_____
External aids (glasses, hearing aids, cane, dentures)

_____
Dentist (name and phone)

_____
Organ donor (yes or no)

_____