Health History Form

Name	
Date of Birth	
Social Security or Insurance ID Number	
Medical Insurance Company Name and Phone Number	
Name of Emergency Contact	
Phone Number of Emergency Contact	
Primary Doctor's Contact Information	
Name and Phone Number of Preferred Hospital	
Location of Advance Directives	
Allergies or Reactions to Medications	
History of Medical Problems (indicate if you have had or are treated for any)	☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes ☐ Asthma/Lung Disease ☐ Thyroid Problem ☐ Kidney Disease ☐ Cancer(Specify):_____ ☐ Depression ☐ Other (Specify):_____ _____