HOPE FOR HISPANIOLA
+DIOS TE BENDIGA+

MEDICAL HISTORY

Date: _____

PERSONAL INFORMATION

Name: _____ Date of Birth: _____

PHYSICIAN & INSURANCE INFORMATION

Primary Care Physician: _____

Physician Phone #: _____

Health Insurance Carrier and Phone #: _____

Policy #: _____ Group ID #: _____

LAST EXAMS & IMMUNIZATIONS

Date of last: Tetanus shot: _____ Physical exam: _____

CURRENT MEDICAL INFORMATION

Current Medical Conditions (what my doctor is currently treating me for):

Current Medications (include over-the-counter medicines and supplements):

Allergies and Type of Reaction (to medicines, foods, pets, etc):

ADDITIONAL MEDICAL HISTORY

Have you been hospitalized (for surgery or other reasons) or had a disabling injury in the last year? ☐ Yes ☐ No

If yes, please describe: _____

Are there any medical problems that run in your family? ☐ Yes ☐ No

If yes, please describe: _____

Other pertinent medical information:

Thank you for providing this information.
It helps us care for you better.