Personal Medical Information – Private and Confidential

Full Name: ____

Address: ____

____

Date of Birth: _______ / _______ / __________ Medicare #: ______________________________

Private Health Insurance: YES / NO Fund: ________________ Member #: __________________

Blood type (if known): ___________________ Sex: M/F

In case of emergency

Emergency contact #1:____

Mobile: ________________________________ Phone: __________________________________

Relationship: ____

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Emergency contact #2:____

Mobile: ________________________________ Phone: __________________________________

Relationship: ____

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Habits

Smoker: YES / NO Do you drink alcohol: YES / NO Drinks per week: ___________________

Do you use recreational drugs? YES / NO If Yes please list: _______________________________

Allergies (please list any known allergies)

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Current medications

Please list all current medications that you are taking.

Name	Description	Dose	Purpose

Vitamins / Food Supplements

Name	Description	Dose	Purpose

Known conditions, events, or previous surgeries

Date	Event

Current medical practitioners

Dr's Name	Specialty	Contact #

Is there anything else a Dr might want to know that may be relevant?

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Do you consent to receiving blood products? YES/NO

Please sign:

____

Full name: ____

Date: __________/ _________ / __________