





# Your Medical History (cont'd)

## Diseases, Illnesses, Symptoms & Medical Conditions

Item	Details (include dates, doctors, treatments, outlook, current status, etc.)
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>

*Your Medical History* (cont'd)

**Doctors & Other Health Care Providers** (primary physician, specialists, pharmacist, dentist, etc)

Name, address & contact info	Type of care given
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>



*Spouse's Medical History* (cont'd)

**Allergies**

Are you allergic to any **drugs, medicines, foods, insect stings, etc.?**     yes    no

If yes, list each allergy below along with its symptoms, treatment, how & when diagnosed, etc.

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

**History of Surgeries & Procedures**

Date & description	Details (include results, outlook, physician's name & location)
<hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/>
<hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/>
<hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/>
<hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/>
<hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/>

# Spouse's Medical History (cont'd)

## Diseases, Illnesses, Symptoms & Medical Conditions

Item	Details (include dates, doctors, treatments, outlook, current status, etc.)
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>

*Spouse's Medical History* (cont'd)

**Doctors & Other Health Care Providers** (primary physician, specialists, pharmacist, dentist, etc)

Name, address & contact info	Type of care given
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>

## *Extended Family's Medical History*

Certain illnesses and diseases tend to run in families, including alcoholism, heart disease, high cholesterol, depression, diabetes, Alzheimer's, muscular dystrophy, and many types of cancer. These and others are believed to have genetic components that can pass from one generation to others.

Outline anything meaningful in your family's medical history below. Next, communicate this information to family members and physicians in order to instigate preventive measures and early diagnosis of symptoms.

Afflicted person's full name, date of birth, and relationship to you	Illness, disease or medical condition + details (include how and when diagnosed, treatments & results, contributing factors such as a tobacco smoker with lung cancer, and the names & locations of physicians)
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>