Adult Health History

To be completed, signed and updated annually

NAME SEX	BIRTH DATE		
ARE YOU CURRENTLY UNDER REGULAR SUPERVISION OF PHYSICIAN?	DATE OF LAST PHYSICAL/MEDICAL EXAMINATION		
NAME OF PHYSICIAN	FAMILY MEDICAL HOSPITAL		
INSURANCE CARRIER	GROUP # MEMBER #		
EMERGENCY CONTACT	PHONE NUMBER		
EMERGENCY CONTACT – NOT LOCAL	PHONE NUMBER		
Past Illness – Check illnesses that you had and specify approximate dates of illnesses:			
	Dates		**Dates**
☐Asthma		☐Diabetes	
☐Seizures		☐Epilepsy	
☐Heart Disease		☐Whooping cough	
☐Bleeding/clotting disorders		☐Other	
SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ALLERGIES			

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I HEREBY GIVE CONSENT TO ____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR _______________________________ (NAME). THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE ADULT NAMED ABOVE.

I HAVE THE FOLLOWING MEDICATION ALLERGIES:

DATE SIGNATURE

HOME ADDRESS

HOME PHONE WORK PHONE