Medical History Form

Patient Information:

First Name:	**MI:**	**Last Name:**	
Address:		**City:**	**Zip Code:**
Date of Birth:		**Age:**	
Phone Number:			

Primary Care Physician's Information:

Physician's Name:	**Physician's Phone:**

Emergency Contact #1:

Name:	**Relationship:**
Phone Number:	

Emergency Contact #2:

Name:	**Relationship:**
Phone Number:	

Past and Existing Medical Conditions or Relevant Injuries (such as major bone breaks or sprains):

Allergies (Medicine or Natural Allergens):

Current Medications (including Epipens):