PERSONAL MEDICAL HISTORY

Name: ____

Date of Birth: ____________ Weight: ______________ Height: ______________

Current Medical Conditions: ________________________________

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Allergies and medications you cannot take: ____________________

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Blood Type: _____ Pharmacy: ________________ Phone # ______________

Include: prescriptions, over-the-counter medications, dietary supplements, vitamins, herbs, medicine patches, inhalers and medicines for pain.

Medication Name	**Dose** (mg, units, puffs, drops)	**Frequency** When do you take it? How many times per day?	**Route** How do you take it?	**Reason** Why do you take it?
Sample Drug	*25 mg*	*1x daily*	*Oral-pill*	*High blood pressure*

- Take your medications as prescribed.
- Do not stop taking any medication before talking with your doctor.