Medical History

PERSONAL HEALTH HISTORY
List All Previous Diagnosis

SURGERIES		
Year	Reason	Hospital / Medical Facility

HOSPITALIZATIONS		
Year	Reason	Hospital/ Medical Facility

Have you ever had a blood transfusion?	☐ Yes	☐ No

PRESCRIBED MEDICATION		
Name of Drug	Dosage	Frequency

ALLERGIES	
Name of Drug	Reaction

FAMILY HEALTH HISTORY					
☐ Asthma .	☐ Thyroid Disease	☐ Epilepsy	☐ Heart Disease	☐ Sickle Cell	☐ Psychological Disorder
☐ Diabetes	☐ Genetic Defects	☐ ADHD	☐ Hemophilia	☐ Cancer	☐Other

List OTHER Family Health Condition: . (If Applicable)	