2014 Medical Information / History

Today's date: _____

Name: _____

Physician's name: _____

Physician's telephone: _____

Are you prone to motion sickness? ☐Yes ☐No

Allergies to foods: _____

Allergies environment: _____

Allergies to medications: _____

Name of medications, dosage, and time taken including vitamins and other supplements:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Histories of surgeries and hospitalizations: _____

_____

_____

_____

_____

Special diet or diet restrictions you want us to know:

_____

_____

_____

_____

Other information you want us to know: _____

_____

_____

_____

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