Health in 30®
Expert Information. Spectacular Health.™

Personal Medical History & Medication Form

Last Name _____ First Name _____ DOB _____

Marital Status _____ Religion _____ ❑ Male ❑ Female

Address _____ State _____ Zip Code _____

Phone (Home) _____ (Work) _____ (Cell) _____

ALLERGIES to Medications: ❑ YES ❑ NO If Yes, list allergies _____

ALLERGIES to Foods, Man-Made Materials, etc.: ❑ YES ❑ NO If Yes, list allergies _____

Insurance Co. _____ Policy No. _____

Emergency Contact: Name _____ Relationship _____

Phone (Home) _____ (Work) _____ (Cell) _____

Who Do You Grant Permission to Speak on Your Behalf? (If Different Than Emergency Contact)

Emergency Contact: Name _____ Relationship _____

Phone (Home) _____ (Work) _____ (Cell) _____

Physicians (Health Care Providers(s)):

Name _____ Specialty _____ Phone _____

Name _____ Specialty _____ Phone _____

Present Medical History: _____

_____

_____

Past Medical History (including place and dates of hospitalizations): _____

_____

_____

_____

_____

Medications: (Prescription, Supplements, Vitamins, Herbal Supplements, Over-the-Counter)

Pharmacy Name & Phone Number _____

Name:	Dose (# milligrams, etc.)	No. of Times Day:	Route (By mouth, injection etc):

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