Medical History Form

Client Information

Full Name: _____
Date of Birth: _____
Gender: _____
Address: _____
Phone Number: _____
Email: _____
Emergency Contact Name: _____
Emergency Contact Phone Number: _____

Primary Care Physician

Physician Name: _____
Phone Number: _____
Address: _____

Health Insurance Information

Insurance Provider: _____
Policy Number: _____
Group Number: _____

Medical History

1. Allergies:
   - _____
   - _____
2. Current Medications (include dosage and frequency):
   - _____
   - _____
3. Chronic Conditions (e.g., diabetes, hypertension, asthma):
   - _____
   - _____
4. Surgeries and Hospitalizations (include dates):
   - _____
   - _____
5. Immunization Record (include dates of last immunizations):
   - _____
   - _____

This form is confidential and will be used solely for the purpose of providing personal care services.

Family Medical History

Heart Disease: Yes / No
Diabetes: Yes / No
Hypertension: Yes / No
Cancer: Yes / No
Other significant family medical history: _____

Lifestyle Information

1. Smoking Status:
    - Current Smoker / Former Smoker / Never Smoked
    - If current or former smoker, how many years?: _____
    - Average number of cigarettes per day: _____
2. Alcohol Consumption:
    - Do you consume alcohol? Yes / No
    - If yes, how often?: _____
3. Exercise Routine:
    - Do you exercise regularly? Yes / No
    - If yes, describe your exercise routine: _____

Current Symptoms or Concerns

_____
_____

Mental Health History

1. Do you have any history of mental health conditions (e.g., depression, anxiety, bipolar disorder)?: Yes / No
    - If yes, please specify:
      _____
2. Have you ever been hospitalized for mental health reasons?: Yes / No
    - If yes, please specify:
      _____

Additional Information

Is there any other information that [Personal Care Agency Name] should be aware of to provide you with the best possible care?

- _____
- _____

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Consent and Acknowledgement

I acknowledge that the information provided above is accurate and complete to the best of my knowledge. I authorize [Personal Care Agency Name] to use this information to create and manage my care plan.

Client Signature: _____ Date: _____

Caregiver/Agency Representative Signature: _____ Date: _____

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