Medical History Form

Each adult household member must complete a separate Medical History Form. Please answer all questions as completely and accurately as possible.

Personal Information

Full Name: _____

Date of Birth: _____

Primary Care Physician: _____

Physician Phone: _____

Date of Last Physical Exam: _____

Medical Conditions

Have you ever been diagnosed with any of the following conditions? Check all that apply:

[ ] Heart disease [ ] Diabetes [ ] Asthma [ ] Cancer [ ] High blood pressure

[ ] Mental health diagnosis [ ] Chronic pain [ ] Neurological disorder

[ ] Other (please specify): _____

If any boxes are checked, please provide details including diagnosis, treatment, and current status:

_____

_____

_____

_____

_____

_____

_____

Current Medications

List all medications you are currently taking (prescription and over-the-counter):

Medication | Dosage | Reason for Use

_____

_____

_____

_____

Mental Health History

Have you ever received counseling or mental health treatment? [ ] Yes [ ] No

If yes, please explain (dates, provider, reason for treatment):

_____

_____

_____

_____

_____

_____

Substance Use

Do you currently use or have a history of using the following?

Tobacco: [ ] Yes [ ] No Alcohol: [ ] Yes [ ] No Recreational drugs: [ ] Yes [ ] No

If yes to any, please explain: _____

_____

_____

_____

_____

_____

_____

_____

_____

Functional Abilities

Do you have any physical or mental health conditions that limit your ability to care for a child?

[ ] Yes [ ] No

If yes, please describe: _____

_____

_____

_____

_____

Certification

I certify that the information provided on this form is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____