



Date: _____

HEALTH HISTORY

This history form provides ID Consultants, PA with information to meet all of your travel needs. *This information is confidential.*

Name: _____
Last First MI

MEDICATIONS: Please list all medications you are currently taking (include dosage)

Medication	Dosage	Medication	Dosage

PHARMACY NAME: _____

PHONE NUMBER: _____

ALLERGIES: Yes No If YES, please list all allergies (foods, medications, environment)

PAST MEDICAL HISTORY: Have you ever had or do you have the following? (Circle “no” or “yes”, leave blank if uncertain)

Alcoholism	yes	no	H/L Blood Pressure	yes	no	<u>Other Conditions (Please List)</u> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____
Anemia	yes	no	High Cholesterol	yes	no	
Arthritis	yes	no	HIV	yes	no	
Asthma	yes	no	Kidney Disease	yes	no	
Cancer	yes	no	Liver Disease	yes	no	
Chemical			Measles	yes	no	
Dependency	yes	no	Meningitis	yes	no	
Diabetes	yes	no	Multiple Sclerosis	yes	no	
Epilepsy	yes	no	Pneumonia	yes	no	
Gonorrhea	yes	no	Polio	yes	no	
Gout	yes	no	Severe Headaches	yes	no	
Heart Trouble	yes	no	Stroke	yes	no	
Hepatitis	yes	no	Syphilis	yes	no	
Herpes	yes	no	Tuberculosis	yes	no	