Personal Medical History

(Please complete a form for each member of your family.)

Name: _____

Date of birth: _____

Name of Family Physician: _____

Contact details of Physician: _____

_____

Name of Dentist: _____

Contact details of Dentist: _____

_____

Name of Eye doctor: _____

Contact details of Eye doctor: _____

_____

Name and contact details of travel health insurance provider:

_____

_____

Other Important Contacts: _____

_____

_____

PRO MEDICONSULT GHANA

1. **Do you have any known allergies or sensitivities to medication, foods or environmental factors?**

_____

_____

_____

2. **What is your current medical condition?**

_____

_____

_____

_____

_____

3. **List all medication that you are taking** (include dosage and how many times you take the medicine each day- include prescription and non- prescription medication):

Name of Medication	Dosage	When taken	Remarks

4. Have you ever been told you had one of the following conditions?

High blood pressure	yes ☐	no ☐
Diabetes	yes ☐	no ☐
Heart trouble	yes ☐	no ☐
Lung disorder	yes ☐	no ☐
Hepatitis	yes ☐	no ☐
Nervous system disorder	yes ☐	no ☐
Disease or disorder of the digestive tract	yes ☐	no ☐
Malaria	yes ☐	no ☐
Disease of the kidney	yes ☐	no ☐
Any form of cancer	yes ☐	no ☐
Disease or disorder of the blood?	yes ☐	no ☐

(describe)_____

Any physical defect or deformity? yes ☐ no ☐

(describe)_____

Any vision or hearing disorders? yes ☐ no ☐

(describe)_____

5. Have you had any surgical operation during the last 5 years (please, describe):

_____

_____

_____

6. Do you have any other important medical information?

_____

_____

_____

_____