

# Teacher Treks Inc Personal Medical History

For \_\_\_\_\_

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**Name:**

**Address:**

**Phone numbers**

Home:

Work:

Cellular:

**Date of Birth:**

**Birthplace:**

**Sex:**

**Health Insurance**

Carrier Name & Address:

Group Number:

Subscriber Number:

Doctor(s) Name	Phone Number	Address
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- 1.
- 2.
- 3.

Current Medications	Medication Allergies
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- 1.
- 2.
- 3.

- 1.
- 2.
- 3.

Food Allergies	Other Allergies
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- 1.
- 2.
- 3.

- 1.
- 2.
- 3.

Previous Illnesses	Previous Surgeries
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- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Date:  
Date:  
Date:  
Date:  
Date:  
Date:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Date:  
Date:  
Date:  
Date:  
Date:  
Date:

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## Immunizations

*This list of vaccines is only an example.*

**Check with your doctor and local U.S. Health Service for your actual immunization schedule.**

	Date	Date	Date	Date	Date
DTP					
T/D					
Oral Polio					
Polio Booster					
MMR					
Other					
Other					

In case of emergency please notify:

\_\_\_\_\_

Telephone Number: area code: \_\_\_\_\_ No \_\_\_\_\_

Address no & street: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ zip \_\_\_\_\_

Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_