Personal Medical History Form
Contact Information

Name: ______________________________

Address

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Home Phone: ______________________

ON Health Card #:____________________

Name of Family
Physician:____________________________

Primary
Contact:

Primary Contact'
Phone #

Alternate
Contact:

Alternate Contact's
Phone #

Medical Information

Personal Medical History Form
Medications/Allergies/Conditions

Do you suffer from or have you suffered from…

	Yes	No
Heart Disease	☐	☐
Epilepsy	☐	☐
Hemophilia	☐	☐
Asthma	☐	☐
Diabetes	☐	☐
Serious Allergies	☐	☐

List allergies (if applicable)

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Do you suffer from or have you suffered from any other medical problems.

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Are you presently taking any medication? Yes ☐ No ☐

If yes, what medications and known side effects?

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