

## **Staff Medical History Form**

Name:	
Position:	Room/Phone Ext:
Address:	
Phone Number(s):	

Are you currently taking any prescription medications? If so, which medications? How often?

Do you have a history of medical allergies? If so, what allergies?

Do you currently have any physical illness or condition that we should be aware of?

Have you had any past surgeries that we should be aware of?

Are there any future surgeries that we should be aware of?

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