

Medical History Form

Name _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____ Date of Birth ____/____/____

Emergency Contact _____ Phone _____ Relationship _____

Are you currently under a doctor's care? _____ Yes _____ No

If yes, please explain _____

Please list any medications you take on a regular basis _____

Have you been hospitalized recently? _____ Yes _____ No

If yes, please explain _____

Have you had any surgery that you think I should be aware of, please explain _____

Do you have any allergies; food, chemical, hay fever type _____ Yes _____ No

If yes, please explain _____

Do you wear contacts? _____ Hearing aid? _____

What is your reason for today's visit? _____

Is there any medical information that wasn't asked that you feel I should be aware of?

Please explain _____

How did you hear about The Right Touch Massage Therapies? _____

Signature _____ Date _____

