Good Samaritan
Wellness Matters

Individual Membership Medical Questionnaire

Applicant Name: _____ **Date of Birth:**_____

CURRENT / PAST MEDICAL HISTORY FOR WHICH YOU ARE/HAVE BEEN TREATED—*Check all that apply:*

_____ Diabetes	_____ Stomach/Colon Prob	_____ Bone Disorder	_____ Depression
_____High Blood Pressure	_____ Thyroid	_____ Arthritis	_____ Bladder Disorder
_____ Heart Disease	_____ Seizures	_____ High Cholesterol	_____ Lung Disease
_____ Heart Attack	_____ Stroke	_____ Cancer	_____ MS
_____ Kidney Disease	_____ Blood Disorder	_____ Mental Illness	_____ HIV/AIDS

Other: _____

Are you currently under the care of a medical provider? _____ Yes _____ No (*If yes, provider name and for what condition.)*

Provider Name: _____ Condition: _____

Provider Name: _____ Condition: _____

Surgical History—Please list previous surgeries with approximate dates:

_____

Medication History (List current medications and dosage. If more space is needed, continue on back):

Medication Name	**Dosage**	**Times per day**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

_____

_____

I attest that the above information is complete and accurate and denotes my complete current and past medical history.

Signature: _____ Today's Date: _____