The Dover Group
Planning for you

Medical Information

Full Name_____:

DOB_____:

SS#_____:

Have you smoked Cigarettes or used any nicotine products in the last 36 months _____?

Height_____: Weight_____:

Please list the name and address of your personal physician(s):

Name and address - Primary Care	Reason Last Consulted
	Date:
	Reason :
Tel:	

Other than your primary, please list any specialist(s) seen in the last 5 years:

Name and address - Specialist	Reason Last Consulted
	Date:
	Reason :
Tel:	

Name and address - Specialist	Reason Last Consulted
	Date:
	Reason :
Tel:	

Please list all current medications:

Current Medications	Times per Day and Dosage	Name of Prescribing MD