THE MASTOCYTOSIS SOCIETY

Mast Cell Disorders

THE MASTOCYTOSIS SOCIETY, INC. PERSONAL HEALTH HISTORY FORM

Name: _____Date of Birth:_____
Religion (optional)_____
Home address:
_____
_____
Phone numbers:
Home_____
Cell_____
Work or other (please specify)_____
Fax number if available: _____ Email address:
_____
Primary care physician name and address: _____
_____
_____
_____

In case of emergency, please contact:
_____
Phone number: _____ For medications, please see separate Medication by Indication list. For allergies, please see Drug allergy list. For list of all attending physicians, please see physician contact list.
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Major Illnesses, please list and age of onset:

Other illnesses you currently have or have had:

Surgeries, year and what part of the body:

Hospitalizations:

Allergies to foods:

Allergies to medications: more detail is given on separate drug allergy list.

Other than medications and foods, what are other major triggers for you?

Do you consider yourself to be stable on a day to day basis in terms of your overall health?

Do you have a history of anaphylaxis? Have you been treated in an ER for anaphylaxis?

Do you carry an Epi-pen or Twin-ject?

Are you on disability? Do you have insurance?