The Mastocytosis Society

The Mastocytosis Society • P.O. Box 731 • Brenham, TX 77834

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.
** **Major Illnesses, please list and age of onset:**

Other illnesses you currently have or have had:

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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?

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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?

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