

MEDICAL HISTORY FORM

DO YOU SUFFER FROM ANY OF THE FOLLOWING CONDITIONS?

HYPERTENSION _____

DIABETES _____ - IF SO, ARE YOU INSULIN DEPENDENT? _____

HEART DISEASE _____ - IF SO, ARE YOU TAKING MEDICATION? _____

SEIZURE DISORDER _____ - IF SO, ARE YOU TAKING MEDICATION? _____

ASTHMA _____

ALLERGIES _____ (FOODS, PLANTS, INSECTS, MEDICATIONS ETC.)

HAVE YOU HAD A RECENT CONCUSSION? _____

DO YOU WEAR CONTACT LENSES? _____

DO YOU KNOW THE DATE OF YOUR LAST TETANUS? _____

PLEASE LIST ANY OTHER PERTINENT MEDICAL HISTORY OR MEDICATION YOU
ARE TAKING _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____

EMERGENCY CONTACTS TELEPHONE NUMBER _____

SIGNATURE/DATE