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