Please provide us with this important information in case of a medical emergency.

Medical History Questionnaire

All Information Is Confidential

Name: _____ Date of Birth: _____

Physician: _____ Phone Number: _____

☐ Yes ☐ No Are you allergic to any medication (aspirin, penicillin, etc.)? List:

_____

☐ Yes ☐ No Do you take any medication? List with reason: _____

_____

☐ Yes ☐ No Have you ever been told by a doctor that you have epilepsy? When?

_____

☐ Yes ☐ No Have you had recent surgical operations, accidents or injuries? When/What?

_____

☐ Yes ☐ No Have you been "knocked out" unconscious, had a concussion or head injury? When?

_____

☐ Yes ☐ No Are you pregnant?

Do you wear: ☐ Glasses or ☐ Contact Lenses?

Date of last tetanus immunization: _____

Please check any of the following medical conditions you have had within the last 5 years:

☐ Asthma
☐ Heart Disease
☐ Diabetes
☐ High Blood Pressure
☐ Fainting Spells
☐ Seizures
☐ Hay fever or allergies
(especially to bees, ants, etc.)

Do you have any medical training?

☐ Doctor ☐ Nurse ☐ Emergency Medical Technician ☐ Other: _____

Name and phone number(s) of person to contact in case of emergency:

_____

Is there anything else about your health you would like us to know in case of an emergency?

_____

_____

_____

_____

_____