Medical History Card

Name:_____

Address: _____

Gender:_____ Birthdate: _____ Age:_____
M/D/Y

Medical Insurance Number: _____

Parent/Guardian Name: _____

Address: _____

Phone Numbers: Home: _____Work: _____ Cell: _____

Alternate Contact Person: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Record of Health

State any illnesses and/or injuries over the past five years:_____

_____

_____

State any surgery: _____

Please check those which have occurred at any time:

Asthma ☐ Diabetes ☐ Heart Disease ☐ Recurring headaches ☐
Seizure ☐ Blackouts ☐ Chest Pain ☐

Year of last tetanus shot: _____

List allergies: _____

_____

List medications currently taking: _____

_____

Do you wear contact lenses? Yes ◯ No ◉

Do you require the use of protective lenses? Yes ◯ No ◉

Physician's Name: _____ Phone Number: _____

Date this card was completed: _____
M/D/Y