MEDICAL HISTORY

COMPLETE ALL SECTIONS

Any serious illnesses? (diabetes, heart disease, seizures, asthma): _____

_____

Recent surgery? _____

Are you pregnant: ☐ No ☐ Yes

No Yes

☐ ☐ Head Injury or Concussion(s): _____

List dates: _____

☐ ☐ Neck or Back Injuries: _____

List dates: _____

☐ ☐ Fractures or Dislocations: _____

List dates: _____

☐ ☐ Chest or Abdominal Injuries: _____

List dates: _____

☐ ☐ Normal Vision?

☐ ☐ Do you wear contacts?

☐ ☐ Normal Hearing?

Last Tetanus Immunization Date: _____

Current Medications: _____

_____

PRIMARY PHYSICIAN

NAME: _____

ADDRESS: _____

_____

PHONE: _____

HEALTH INSURANCE INFORMATION:

CARRIER: _____

CARD #: _____

_____

INSURED/NAME OF CARDHOLDER: _____

USPC MEDICAL CARD

NAME: _____

DATE OF BIRTH: _____ ☐M ☐F

ADDRESS: _____

_____

PHONE: _____

ALLERGIES (all): _____

_____

_____

EMERGENCY CONTACT: (MUST BE OTHER THAN SELF)

NAME: _____

PHONE: _____

PHONE: _____

NAME: _____

PHONE: _____

PHONE: _____

NAME: _____

PHONE: _____

PHONE: _____

RELEVANT INJURIES AND MEDICAL CONDITIONS

Date of Diagnosis/ Accident	Type of Injury/ Severity of Condition	Treating Doctor Name/Phone