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MEDICAL CONDITIONS

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(Check all that exist)

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|------------------------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> No known Medical Conditions                   | <input type="checkbox"/> Hemodialysis       |
| <input type="checkbox"/> Abnormal EKG                                  | <input type="checkbox"/> Hemolytic Anemia   |
| <input type="checkbox"/> Adrenal Insufficiency                         | <input type="checkbox"/> Hepatitis-Type____ |
| <input type="checkbox"/> Angina                                        | <input type="checkbox"/> HIV/AIDS           |
| <input type="checkbox"/> Asthma                                        | <input type="checkbox"/> Hypertension       |
| <input type="checkbox"/> Bleeding Disorder                             | <input type="checkbox"/> Hypoglycemia       |
| <input type="checkbox"/> Cancer                                        | <input type="checkbox"/> Laryngectomy       |
| <input type="checkbox"/> Cardiac Dysrhythmia                           | <input type="checkbox"/> Leukemia           |
| <input type="checkbox"/> Cataracts                                     | <input type="checkbox"/> Lymphomas          |
| <input type="checkbox"/> Clotting Disorder                             | <input type="checkbox"/> Memory Impaired    |
| <input type="checkbox"/> Coronary Bypass Graft                         | <input type="checkbox"/> Myasthenia Gravis  |
| <input type="checkbox"/> Dementia <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Pacemaker          |
| <input type="checkbox"/> Diabetes/Insulin Dependent                    | <input type="checkbox"/> Renal Failure      |
| <input type="checkbox"/> Eye Surgery                                   | <input type="checkbox"/> Seizure Disorder   |
| <input type="checkbox"/> Glaucoma                                      | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Hearing Impaired                              | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Heart Valve Prosthesis                        | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Other:                                        | <input type="checkbox"/> Vision Impaired    |
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ALLERGIES

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- |                                         |                                        |                                       |
|-----------------------------------------|----------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin        | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Barbiturate    | <input type="checkbox"/> Latex         | <input type="checkbox"/> Sulfa        |
| <input type="checkbox"/> Codeine        | <input type="checkbox"/> Lidocaine     | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Demerol        | <input type="checkbox"/> Morphine      | <input type="checkbox"/> X-Ray Dyes   |
| <input type="checkbox"/> Horse Serum    | <input type="checkbox"/> Novacaine     | <input type="checkbox"/> No Known     |
| <input type="checkbox"/> Environmental: |                                        |                                       |
| <input type="checkbox"/> Other:         |                                        |                                       |
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MEDICAL INSURANCE

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Med Ins Co:

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Policy #:

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Other Med Ins Co:

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Policy #:

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Medicaid #:

Medicare #:

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