

Medical History

NAME: _____ **AGE:** _____
RACE: _____ **GENDER:** _____ **BIRTHDAY:** _____

DATE OF LAST TETANUS IMMUNIZATION: _____

ARE YOU CURRENTLY TAKING MEDICATIONS? (Yes / No)

If yes please list all medications: _____

PLEASE LIST ALL CURRENT MEDICAL CONDITIONS: _____

PLEASE LIST ALL KNOWN ALLERGIES: _____

DO YOU HAVE ANY SPECIAL DIETARY RESTRICTIONS? (Yes / No)

If yes please explain: _____

**Please make a photo copy of your health insurance card and
attach it to this form.**
