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): ______ H INFORMA

Neck or Back Injuries:_____

Fractures or Disloca!ons:_____

List dates: _______
Chest or Abdominal Injuries: ______

List dates: _____

List dates: ______Do you wear contacts? ______Normal Hearing? Last Tetanus Immuniza!on Date: ____

Current Medica!ons: ____

NAME: ___

USPC MEDICAL CARD

PRIMARY PHYSICIAN	DATE OF BIRTH:
NAME:	ADDRESS:
ADDRESS:	
	PHONE:
PHONE:	ALLERGIES (all):
HEALTH INSURANCE List dates:	EMERGENCY CONTACT: (MUST BE OTHER THAN SELF)
TION:	NAME:
	PHONE:
CARRIER:	PHONE:
CARD #:	NAME:
	PHONE:
	PHONE:
	NAME:
INSURED/NAME OF	PHONE:
CARDHOLDER:	PHONE:
al Vision?	

____ RELEVANT INI

RELEVANT INJURIES AND MEDICAL CONDITIONS

Date of Diagnosis/ Accident	Type of Injury/ Severity of Condilon	Trea!ng Doctor Name/Phone
	,	,