

MEDICAL PARTICULARS, CONDITIONS, AND HISTORY

Name _____ Date _____

Medical particulars (e.g., corrective lenses, pacemaker, artificial joint or limb)

_____ Blood type _____

Existing medical conditions (e.g., allergy, high blood pressure, heart disease, cancer, phobia, depression)

Medical history		
Problem _____		
Treatment _____	Date(s) _____	
Physician _____	Facility _____	
Problem _____		
Treatment _____	Date(s) _____	
Physician _____	Facility _____	
Problem _____		
Treatment _____	Date(s) _____	
Physician _____	Facility _____	
Problem _____		
Treatment _____	Date(s) _____	
Physician _____	Facility _____	