



2017 MEDICAL CARD

PLEASE TYPE OR PRINT CLEARLY

NAME _____	DOB _____	GENDER _____
ADDRESS _____		
CITY _____	STATE _____	ZIP _____ COUNTRY _____
HOME PHONE _____	CELL PHONE _____	
WORK PHONE _____	DATE OF LAST TETANUS _____	
BLOOD TYPE _____	DO YOU WEAR CONTACTS? _____	
DRUG ALLERGIES _____		
CURRENT MEDICATION _____		
CHRONIC MEDICAL CONDITIONS FOR WHICH YOU ARE BEING TREATED _____		

MAJOR ILLNESS OR SURGERIES IN THE PAST 12 MONTHS _____		

PRIMARY DOCTOR _____	PHONE # _____	
EMERGENCY CONTACT _____	PHONE # _____	