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 #_____