MEDICAL REPORT FORM

2020

MEMBER INFORMATION

Name : First name:	Date of Birth :
Address : Zip code : City :	
Mobile phone :___/___/___/___/___	House phone :___/___/___/___/___

MEMBER MEDICAL HISTORY

Are you presently under medical care for a medical health problem? YES ☐ NO ☐
if yes, describe the problem(s) and treatment(s)

List of medication that you are taking	History of serious illnesses and injuries (include dates) : History of surgery (include dates)
Do you wear glasses? YES ☐ NO ☐ Do you wear contact lenses? YES ☐ NO ☐ Do you smoke cigarettes? YES ☐ NO ☐ Do you drink alcoholic beverages? YES ☐ NO ☐	List any allergies to medications and describe the reaction : List any food and/or environmental allergies and describe the reaction

IMMUNIZATIONS REQUIREMENT

			DATE (m/d/y)
Hepatitis B	YES ☐	NO ☐	____/____/____
Tetanus	YES ☐	NO ☐	____/____/____
Diphteria	YES ☐	NO ☐	____/____/____
DT Polio	YES ☐	NO ☐	____/____/____

			DATE (m/d/y)
Rubella	YES ☐	NO ☐	____/____/____
Measle	YES ☐	NO ☐	____/____/____
BCG	YES ☐	NO ☐	____/____/____
Whooping-cough	YES ☐	NO ☐	____/____/____

CERTIFICATION OF HEALTH CARE PROVIDER

X_____ _____ Date :_____

SIGNATURE PRINTED NAME MONTH/DATE/YEAR

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