DRIVER MEDICAL HISTORY

Name _____ Age _____ Date of Birth _____

Address _____City _____ St ____ Zip _____

Email Address _____ Occupation _____

Phone (H) _____ (W)_____ (C) _____

Personal Physician _____ Phone _____

Address _____City _____ St ____ Zip _____

Emergency Contact Information:

Name: _____Phone: _____

Please indicate if you have ever had, or have now, any of the following conditions:

Condition	Yes	No
Frequent or severe headaches		
Unconsciousness for any reason		
Dizziness or fainting spells		
Epilepsy or seizures		
Coronary artery disease or angina		
Heart valve disease		
Left Bundle Brach Block (heart)		
Abnormal cardiac rhythms		
High blood pressure		
Any drug, narcotic, or alcohol problems		
Operation(s) on brain		
Operation(s) on heart		
Operation(s) on eyes, nerves, blood vessels, or bone		
Eye trouble (except glasses)		
Asthma		
Diabetes		
Anemia or other blood diseases including abnormal bleeding		
Admission to a hospital in the past 12 months		
Allergy(s) to medications		

Illness(es) not listed above - List:

_____

_____

Date of last Tetanus Shot: _____Blood Type _____Blood Thinner Medication (circle) YES NO

Medications Used (including eye drops):

_____

_____

_____

I certify that the above is true and correct information.

Driver's Signature

_____ **Date**

_____