



ICSCC 2009 MEDICAL HISTORY APPLICATION

(To be filled out by the Applicant
whether or not you require a physical exam by doctor)

Name: _____	Birthdate: _____	Sex: _____
Address: _____		
City: _____	State/Prov: _____	Code: _____
Home Phone: () _____	Work Phone: () _____	
Occupation: _____		

Personal Physician: _____		
Physician's Address: _____	Phone: () _____	
City: _____	State/Prov: _____	Code: _____

Examining Physician (if applicable): _____		
Physician's Address: _____	Phone () _____	
City: _____	State/Prov _____	Code _____

DO YOU HAVE A HISTORY OF THE FOLLOWING? (Please Check)

	NO	YES
1. Frequent or unusual headaches? _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Fainting spells? _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Unconsciousness? _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Eye disorder? _____ Wear glasses? _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Nervous System disorders? _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Allergies _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Heart or circulation disorders? _____	<input type="checkbox"/>	<input type="checkbox"/>
10. High or Low Blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>
11. Anemia or easy bleeding _____	<input type="checkbox"/>	<input type="checkbox"/>
12. Intestinal disorder? (Stomach, colon, etc.) _____	<input type="checkbox"/>	<input type="checkbox"/>
13. Kidney stone or tumor _____	<input type="checkbox"/>	<input type="checkbox"/>
14. Psychiatric problems _____	<input type="checkbox"/>	<input type="checkbox"/>
15. Treatment for alcoholism or drug habit _____	<input type="checkbox"/>	<input type="checkbox"/>
16. Attempted suicide _____	<input type="checkbox"/>	<input type="checkbox"/>
17. Admission to hospital for surgery, or other reason _____	<input type="checkbox"/>	<input type="checkbox"/>
18. Rejection for life or disability insurance _____	<input type="checkbox"/>	<input type="checkbox"/>
19. Medical rejection from or for military service _____	<input type="checkbox"/>	<input type="checkbox"/>
20. Disability compensation for any reason _____	<input type="checkbox"/>	<input type="checkbox"/>

Please use reverse side for details and list all medications (prescription or over-the-counter) being used.

I certify that my answers are true and accurate; I also give permission for any hospital, institution or physician to give specific details.

APPLICANT'S SIGNATURE: _____ DATE: _____