ICSCC 2017 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?	❑	❑
2.	Fainting spells?	❑	❑
3.	Unconsciousness?	❑	❑
4.	Eye disorder? _____ Wear glasses?	❑	❑
5.	Nervous System disorders?	❑	❑
6.	Asthma	❑	❑
7.	Allergies	❑	❑
8.	Diabetes	❑	❑
9.	Heart or circulation disorders?	❑	❑
10.	High or Low Blood pressure	❑	❑
11.	Anemia or easy bleeding	❑	❑
12.	Intestinal disorder? (Stomach, colon, etc.)	❑	❑
13.	Kidney stone or tumor	❑	❑
14.	Psychiatric problems	❑	❑
15.	Treatment for alcoholism or drug habit	❑	❑
16.	Attempted suicide	❑	❑
17.	Admission to hospital for surgery, or other reason	❑	❑
18.	Rejection for life or disability insurance	❑	❑
19.	Medical rejection from or for military service	❑	❑
20.	Disability compensation for any reason	❑	❑

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: _____