

MSA APPLICANT'S MEDICAL HISTORY

(To be completed by applicant)

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 Branch 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**

Comments and details of any condition noted above:

Medications Used (including eye drops):

I certify that the above is true and correct information.

Applicant's Signature

_____ **Date** _____