



AMBULETTE DRIVER MEDICAL HISTORY

Name: _____	Sex M F	Date of Birth _____	Social Security Number _____
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Have you had or do you now have any of the following conditions? Check (✓) 'Yes' or 'No.' Indicate age when condition occurred.

	Yes	No	Age		Yes	No	Age		Yes	No	Age
Allergies, hay fever, drug reaction				Epilepsy or seizures				Other autoimmune disorder(s)			
Ankle weakness				Eye trouble, injury, blindness				Paralysis			
Asthma				Fibromyalgia				Polio			
Anemia or blood disease				Foot trouble				Rectal disease, blood in stool, hemorrhoids			
Back trouble				Headaches, frequent or severe				Rheumatic fever			
Bone or joint deformity				Hearing loss				Rheumatism or arthritis			
Bowel trouble				Heart trouble				Sexually transmitted diseases (STD)			
Broken bone(s)				Hepatitis or liver disease				Shoulder, painful or "trick"			
Cancer or tumor				Hernia				Sinus trouble			
Chest pain or pressure				High blood pressure				Skin disease			
Chronic cough				Hives				Thyroid trouble			
Compromised immune system				Kidney stone or blood in urine				Tuberculosis			
Diabetes				Knee, painful, "trick" or "locked"				Ulcers			
Dizziness/fainting spells, head injury or loss of consciousness				Memory loss				Varicose veins			
Elbow, painful or "trick"				Nervous breakdown				Other			

Yes	No	HISTORY
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been hospitalized? Date(s): Reason: _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had surgery? Date(s): Type of surgery: _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had any major illnesses in the past five (5) years? Date(s): Condition: _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you currently being treated for a medical condition? Condition: _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you currently taking any medications either prescribed or over the counter (include birth control pills or herbs)? List medication(s): _____

Yes	No	PERSONAL HABITS
<input type="checkbox"/>	<input type="checkbox"/>	Do you now or have you ever smoked or used tobacco products? Type: _____ Amount per day: _____ # of years: _____ Quit (date): _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you presently consume alcoholic beverages? Type: _____ # Days per week _____ Amount per day: _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise regularly? Type: _____ # Days per week: _____

Patient Signature: _____ Date: _____