David V. Moore Grand Guild Heroines of Templar Crusades
State of Ohio and Its Jurisdiction, PHA
MEDICAL PROFILE FORM

Name:_____

Address:_____

City:_____State:_____Zip Code:_____

Home Telephone:_____Cell:_____

Jurisdiction:_____

Patient History

Do you have asthma?	Yes ☐	No ☐
Do you have diabetes?	Yes ☐	No ☐
Do you have history of high blood pressure?	Yes ☐	No ☐
Do you have high cholesterol?	Yes ☐	No ☐
Have you had a stroke	Yes ☐	No ☐
Have you had a heart attack?	Yes ☐	No ☐
Do you have bone, joint, or muscle issues?	Yes ☐	No ☐
Have you had seizures?	Yes ☐	No ☐
Do you have Neuropathy?	Yes ☐	No ☐
Are you on dialysis? If yes, state times per week?_____	Yes ☐	No ☐

Allergies: Include medicine, foods, animals, insect bites/stings (dust, pollen, etc.)

Yes ☐ No ☐

Allergy	Reaction	Medication (if any)

Emergency Contact:_____

Relationship:_____

Home Telephone:_____Cell:_____

If the above person is unavailable, please notify:_____

Relationship:_____

Home Telephone:_____Cell:_____

WRD,GPC 2019