

# Applicant's Medical History

(to be filled out by candidate)

Applicant \_\_\_\_\_ Spouse \_\_\_\_\_

Address \_\_\_\_\_

Phone (day) \_\_\_\_\_ (night) \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Occupation \_\_\_\_\_

## Have you been treated for, ever had, or have you now, any of the following?

(For each "YES" checked, describe or explain below or on the back of this sheet)

| Yes | Condition or disease   | No |
|-----|--|----|
|     | 1. Frequent or severe headaches, dizziness or fainting spells            |    |
|     | 2. Epilepsy or stroke, unconsciousness for any reason                    |    |
|     | 3. Eye problems (not including glasses), color blindness                 |    |
|     | 4. Asthma or other breathing problems, shortness of breath, lung disease |    |
|     | 5. Diabetes (insulin dependent?)   |    |
|     | 6. Heart attack, angina, heart failure, irregular heart beat             |    |
|     | 7. High or low blood pressure  |    |
|     | 8. Anemia or other blood diseases, tendency to bleed                     |    |
|     | 9. Kidney or urinary tract disease                                       |    |
|     | 10. Hospital stay in last 12 months                                      |    |
|     | 11. Operations involving eyes, brain, heart, nerves or blood vessels     |    |
|     | 12. Allergy to medications   |    |
|     | 13. Amputation or physical disability                                    |    |
|     | 14. Alcoholism or drug abuse   |    |
|     | 15. Other serious illnesses  |    |

16. Date of last Tetanus booster \_\_\_\_\_ 17. Blood type (if known) \_\_\_\_\_

Remarks (use back of page if necessary) \_\_\_\_\_

Medicines currently used (including eye drops) \_\_\_\_\_

I certify all of the above statements are true and accurate. I authorize to any hospital, institution or physician permission to release medical information which might have bearing on my ability to drive a vintage race car in competitive events. I also agree to notify the organization holding this medical form of any changes which occur during the life of this medical certification which might affect my ability to safely race a car at speed.

Signed \_\_\_\_\_ Date \_\_\_\_\_