International Grand Court Order of Cyrene Crusaders
Auxiliary to the Grand Encampment of Knights Templar
United States and its Jurisdictions, P.H.A., Inc.

MEDICAL PROFILE FORM

Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home: _____ 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?	**YES ___ NO ___ (If yes state times per week____.)**

Allergies: Include medicine, foods, animals, insect bites/stings (dust, pollen, etc.) **NONE**

Allergy	Reaction	Medication (if any)

MEDICAL HISTORY

Please list all prescription, over-the-counter, and natural medications you are taking.

Medication	Dosage	Frequency	Side Effects	Reason for Taking

PHYSICAL EXAMINATION

Date of most recent physical: __/__/__ BP ____Glucose _____Protein _____PSA ____Blood _____
Other: _____
_____
Impression: _____
Physician's name: _____
Address: _____ Phone number: _____
Signature (required):_____ Date: _____

EMERGENCY CONTACT

Emergency Contact: _____ Relationship: _____
Home: _____ Cell: _____
If the above person is unavailable, please notify: _____ Relationship: _____
Home: _____Cell: _____

To insure privacy please return completed form to: Aaron Beason, 309-B McNair Street, Tuskegee, AL 36803
Phone: (334) 777-4085 Email: Beasonaaron4@gmail.com