

Medical Information / History

Today's date: _____

Name: _____

Passport number: _____

Physician's name: _____

Physician's telephone: _____

Are you prone to motion sickness? Yes No

Allergies to foods: _____

Allergies environment: _____

Allergies to medications: _____

Name of medications, dosage, and time taken including vitamins and other supplements:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Histories of surgeries and hospitalizations: _____

Other information you want us to know: _____

