

J. Current Medications

Please note all prescription or over-the-counter medications you take regularly:

K. Blood Type

A B AB O RH Factor: + -

Have you ever been turned down for a blood donation? Yes No

Why? _____

L. Past Medical History - Part I

Do you now or have you ever had any of the following?

	Yes	Date (mo/yr)		Yes	Date (mo/yr)		Yes	Date (mo/yr)
Diabetes	<input type="checkbox"/>	/	Cancer	<input type="checkbox"/>	/	Heart Attack	<input type="checkbox"/>	/
High Blood Pressure	<input type="checkbox"/>	/	Stroke	<input type="checkbox"/>	/	Epilepsy (Seizures)	<input type="checkbox"/>	/
Severe Headaches	<input type="checkbox"/>	/	Mental Disorder	<input type="checkbox"/>	/	Tuberculosis	<input type="checkbox"/>	/
Asthma	<input type="checkbox"/>	/	Hayfever	<input type="checkbox"/>	/	Bronchitis	<input type="checkbox"/>	/
Stomach Ulcers	<input type="checkbox"/>	/	Liver Disease	<input type="checkbox"/>	/	Colitis/Bowel Problems	<input type="checkbox"/>	/
Hernia	<input type="checkbox"/>	/	Kidney Disease	<input type="checkbox"/>	/	Gout	<input type="checkbox"/>	/
Arthritis	<input type="checkbox"/>	/	Varicose Veins/Phlebitis	<input type="checkbox"/>	/	Anemia	<input type="checkbox"/>	/
Bleeding Disorder	<input type="checkbox"/>	/	Thyroid Disease	<input type="checkbox"/>	/	Deafness	<input type="checkbox"/>	/
Blindness	<input type="checkbox"/>	/	Obesity	<input type="checkbox"/>	/	Alcohol/Drug Dependency	<input type="checkbox"/>	/
Suicidal Tendencies	<input type="checkbox"/>	/	Pancreatitis	<input type="checkbox"/>	/	Gall Bladder Disease	<input type="checkbox"/>	/
Glaucoma	<input type="checkbox"/>	/	Syncope/Faintness	<input type="checkbox"/>	/	Coronary Artery Disease	<input type="checkbox"/>	/
Irregular Heart Beats	<input type="checkbox"/>	/	Cataract	<input type="checkbox"/>	/			

M. Past Medical History - Part II

Date of last dental visit: ____ / ____ / ____

Reason for visit: _____

Date of last physician visit: ____ / ____ / ____

Reason for visit: _____

If tests were performed and abnormal results were recorded, please ask your physician to send a medical summary to Motorola Assist

Do you have religious/moral objections to:

	Yes	No		Yes	No		Yes	No		Yes	No
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant	<input type="checkbox"/>	<input type="checkbox"/>	Medications	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>

N. Hospitalizations and/or Surgeries

Date of Admission	Hospital	Location	Length of Stay	Diagnosis
____ / ____ / ____	_____	_____	_____	_____
____ / ____ / ____	_____	_____	_____	_____
____ / ____ / ____	_____	_____	_____	_____
____ / ____ / ____	_____	_____	_____	_____

I confirm the above information, to the best of my knowledge, is correct. I hereby authorize International SOS Assistance, Inc., acting as agent for Motorola Assist, to deliver, disclose, and receive all information concerning the past medical history and current medical care rendered to myself, including diagnosis, treatment, and medical records.

Print Name _____

Signature of Employee _____

Date _____

Please complete and forward this form to: Motorola Assist, 8 Neshaminy Interplex, Suite 207, Trevose, PA 19053
FAX: (215) 244-9617