

APPLICANT'S MEDICAL HISTORY

(To be completed by applicant)

Applicant: For the purpose of obtaining a Competition License, complete this page legibly and in its entirety. Failure to complete required information will delay the processing of your license. Examining Physician must complete the reverse side of this form.

Name: _____ Age: _____ Date of Birth: _____

Address: _____ City, St. Zip: _____

Phone: (H) _____ (W) _____ E-mail _____

Occupation: _____ Sex: _____ Martial Status: _____ Years as licensed racer: _____

Your Personal Physician: _____ Phone: () _____

Address: _____ City, St. Zip: _____

Examining Physician : _____ Phone: _____

Address: _____ City, St. Zip: _____

A. Have you been treated for, have you ever had, or have you now, any of the following:

(Yes responses should be explained on a separate sheet and attached when submitted)

Conditions	Yes	No
Frequent or severe headaches		
Unconsciousness for any reason		
Dizziness or fainting spells		
Epilepsy or Seizures		
Heart Trouble: Coronary Artery Disease or Angina Valve disease Left Bundle Brach Block Abnormal Cardiac Rhythms		
High Blood Pressure		
Any drug, narcotic or alcohol problems		
Psychiatric/Mental Health Problems		
Operation(s) involving Eyes, Brain, Heart, Nerves, Blood Vessels, or Bones		
Previous waiver(s) for a medical condition: List:		

Conditions	Yes	No
Hay fever		
Eye trouble (except glasses)		
Asthma		
Diabetes		
Anemia, or other blood diseases including abnormal bleeding		
Admission to a hospital in the past 12 months		
Allergy(s) to medications List:		
Amputations /Physical disability		
Previous denial(s due to a medical reason(s) List:		
Illness not mentioned above List:		

Date of last Tetanus: _____ Blood Type (if known): _____

Comments: _____

Medications Used (including eye drops): _____

This is to certify that these statements are true and accurate.

Applicant's Signature: _____ **Date:** _____

PHYSICIAN'S EXAMINATION To be completed by a Medical Doctor

Applicant's Name: _____ Age: _____ Sex: _____ Height: _____

Weight: _____ Hair Color: _____ Eye Color: _____

Blood Pressure: _____ Pulse: _____ Respirations: _____

NOTE: Candidates having the following afflictions must be referred to the Medical Board for review:

- Less than 20/40 corrected vision in the better eye
- Alcoholic or drug addiction
- Blood pressure: Diastolic over 90, systolic over 160
- All gross deformities subject to listing
- Loss of extremity or eye
- Diabetes
- Loss of color vision
- Psychological problems
- Epilepsy
- History of Heart Attack

VISION Abnormalities require an attached ophthalmological consult

Vision OD: _____ OS: _____ OU: _____

Color Vision: _____ Test: _____

Peripheral Vision (degrees from midline): _____ OD: _____ OS: _____ Test: _____

NEUROLOGICAL Abnormalities require an attached neurological consult

Reflexes: _____ Normal _____ Abnormal Cerebellar: _____ Normal _____ Abnormal

Other tests performed: _____

CARDIAC Abnormalities require an attached cardiologic consult

At the age of 40, a baseline EKG should be performed. Further EKG's need to be completed only if the candidate is a smoker, has a cardiac history, a strong family history of cardiac disease, history of diabetes, or has hypertension

(sys-tolic > 140, diastolic > 90). Cardiac Exam: _____ Normal _____ Abnormal

Please attach a copy of the EKG results.

METABOLIC Please attach an HgbA1C and Endocrinologic consult for any history of Diabetes.

History of Diabetes: _____ Yes _____ No HgbA1C (less than 10) _____

Comments or concerns that the Medical Board should be aware of: _____

Comments regarding current medications the applicant is taking (any side effects): _____

Examining Physician's Comments regarding applicant's medical history: _____

On the basis of this limited examination, review of the patient's history, and the instructions addressed to me, I (check one):

_____ Find the candidate medically acceptable to operate a high speed competition automobile.

_____ Recommend the candidate's medical history be reviewed by the Medical Board.

Signed: _____ **Date:** _____

Printed Name: _____ Phone: _____

Address: _____ City, St. Zip _____