

"THINGS WE NEED TO KNOW ABOUT YOU"

NAME: AGE

RES. ADDRESS:

EMAIL ID:

HOME TELEPHONE: YOUR MOBILE NO.

ALT. CONTACT PERSON: CONTACT MOBILE:

MEDICAL DETAILS:

YOUR BLOOD GROUP

DO YOU SUFFER FROM:

TRAVEL SICKNESS	YES/NO	<input type="text"/>
BACK/NECK AILMENTS	YES/NO	<input type="text"/>

Describe:

BLOOD PRESSURE	YES/NO	<input type="text"/>
DIABETES	YES/NO	<input type="text"/>
HEART AILMENT	YES/NO	<input type="text"/>

Describe:

ASTHMA, WHEEZING ETC	YES/NO	<input type="text"/>
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Describe:

ALLERGIC TO:	YES/NO	<input type="text"/>
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Describe:

MAJOR INJURY EVER	YES/NO	<input type="text"/>
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Describe: