

Adult Health History Record

Name: _____ Date of Birth: _____ Age: _____

Full Address: _____ Phone: _____

Email Address: _____ Alternate Phone: _____

Emergency Contact:

Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

Physician: _____ Physician's Phone: _____

Medical/Hospital Insurance Carrier: _____ Policy/Group #: _____

Date of last health exam _____ List any medical problems noted _____

Date of last Tetanus shot _____

Is participant currently under physician's or psychologist's care? yes no Issue: _____

Special Accommodations Needed: _____

Allergies (please attach additional sheet if needed):

Item: _____ Reaction: _____ Life Threatening: YES NO Next Step: _____

Item: _____ Reaction: _____ Life Threatening: YES NO Next Step: _____

Item: _____ Reaction: _____ Life Threatening: YES NO Next Step: _____

Since last health exam, has participant had (If you check any of the items below, please explain. Use additional paper as needed):

- | | |
|--|--|
| <input type="checkbox"/> a serious injury requiring medical attention? | <input type="checkbox"/> an illness lasting more than 5 days? |
| <input type="checkbox"/> any prescribed or over-the-counter meds? | <input type="checkbox"/> any restriction concerning physical activities? |
| <input type="checkbox"/> a surgical operation or fracture? | <input type="checkbox"/> any exposure to a contagious disease? |
| <input type="checkbox"/> treatment in hospital or emergency room? | <input type="checkbox"/> Other (specify): _____ |

Illnesses (Chronic or Recurring) & Injuries (Check those that apply and give dates of last incident):

- | | | |
|--|--|--|
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Heart Defect/Disease _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Bleeding/Clotting Disorders _____ | <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Musculoskeletal Disorders _____ | <input type="checkbox"/> Other (specify) _____ |

Other Health Conditions (Check those that apply, explain any checked items)

- | | | |
|--|---|---|
| <input type="checkbox"/> Emotional Disturbances | <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Sleep Disturbances |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Special Dietary Regimen |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Sickle Cell Trait/Immune Disease | <input type="checkbox"/> Wears Glasses/Contact Lenses |
| <input type="checkbox"/> Others (specify): _____ | | |

This health history is complete and accurate. I know of no reason(s), why I should not participate in activities except as noted. I understand that if my health condition or health insurance information should change it is my responsibility to update this form. If necessary, I hereby give permission to the physician indicated above or qualified personnel to secure and administer treatment, including hospitalization for myself.

Signature: _____ **Date:** _____