Health History

Name ______________________________ Age ______ Gender _____

Birth Date ____________

Address ____________________________ City ______________________

State ____ Zip _______

Home Phone ( ) ________________________ Work Phone ( ) ____________

Emergency Contact ______________________________ Phone ( ) ________

Doctor's Name & Phone __________________________________ ( ) ________

Immunizations: DPT _______ Polio _______ Tetanus Booster _________

Conditions: Asthma______ Epilepsy______ Diabetes______ Heart Trouble______
Other____________

Allergies: Insect Stings_____ Hay Fever______ Penicillin______
Other______________________

Food Allergies: Please list

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Please list all medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

_____I take NO medications on a regular basis. _____I take medications as follows:

Med #1________________________ Dosage______________
Time taken__________

Reason:
____

Med #2________________________ Dosage______________
Time taken__________

Reason:
____

List others as necessary on other side.

Serious accidents, injuries, or other important information we should have:

____

____

Special Needs: If you have special needs (dietary, health restrictions, mobility limitations, extra supervision, diabetes, seizures, etc.) please list:

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