Medical History Form (Form #12)

Participant's Name: _____ Birth date: _____

Address: _____

Father's Name: _____ Phone number (s): _____
(or Guardian)

Mother's Name: _____ Phone number (s): _____
(or Guardian)

Physician: _____ Phone number: _____

Dentist: _____ Phone number: _____

Eye doctor: _____ Phone number: _____

Other: _____ Phone number: _____

Participant's current medical condition:

_____

_____

List any prescription and non-prescription medications participant is taking:

_____

Drug sensitivity and allergies (describe):_____

Name of health insurance carrier: _____Group #:_____

Has the participant ever had one of the following?

Lung disorder……..yes/ no
High blood pressure ……...yes/ no
Heart trouble ……..yes/ no
Nervous disorder ……yes/ no
Disease or disorder of the digestive tract …...yes/ no
Any form of cancer ……yes/ no
Disease of the kidney ……yes/ no
Diabetes ……yes/ no
Arthritis …….……yes/ no
Hepatitis …….yes/ no
Malaria ……..…..yes/ no

Disease or disorder of the blood? (describe)_____

Any physical defect or deformity? (describe)_____

Any vision or hearing disorders? (describe)_____

Any life-threatening conditions? (describe)_____

Any contagious disorders? (describe)_____

Has the participant been treated by a physician or been disabled or hospitalized during the last year? (describe)_____

_____

Have the participant had or been advised to have a surgical operation within the last five years? (describe) _____

_____

Date of last physical: _____Date of last tetanus shot _____
Family history (List important medical problems):
Mother:
_____
Father:
_____

Any other special medical information:
_____

_____
Signature of individual completing this form

_____ _____
Printed name Date Completed