MEDICAL HISTORY FORM

Participants Name:

Date:

DO YOU SUFFER FROM ANY OF THE FOLLOWING CONDITIONS?

HYPERTENSION? _____

DIABETES? _____ IF SO, ARE YOU INSULIN DEPENDENT? _____

HEART DISEASE? _____ IF SO, ARE YOU TAKING MEDICINE? _____

SEIZURES? _____ IF SO, ARE YOU TAKING MEDICATION? _____

ASTHMA _____

ALLERGIES (FOODS, PLANTS, INSECTS, MEDICATIONS ETC.). IF SO, PLEASE DESCRIBE:

HAVE YOU HAD A RECENT CONCUSSION? _____

DO YOU WEAR CONTACT LENSES? _____

DO YOU KNOW THE DATE OF YOUR LAST TETANUS SHOT? _____

PLEASE LIST ANY PERTINENT MEDICAL HISTORY OR MEDICATION YOU ARE TAKING:

_____

PERSON TO CONTACT IN THE CASE OF AN EMERGENCY

NAME: _____

PHONE NUMBER: _____