



Adult Health History Record

(To be completed and signed by the adult--the information will be kept confidential.)

Name		Date of birth	
Address		City and Zip	
Daytime phone	Evening phone	Cell phone	
In emergency notify		Relationship	
Daytime phone	Evening phone	Cell phone	
Name of physician		Phone	
Name of dentist		Phone	

Chronic or Recurring Illnesses (check those that apply and give appropriate dates)

- Ear infection
- Bleeding/clotting disorders
- Hypertension
- Asthma
- Other (specify) _____
- Heart defect/disease
- Musculoskeletal disorders
- Seizures
- Diabetes

Date of last health examination: _____ Please note any complicating medical problems determined in last health examination:

Is participant currently under the care of a physician, psychiatrist or psychologist? Yes No

Since last health exam has participant had:	Yes	No	Please explain any "yes" answers to these questions. Include dates.
A serious injury requiring medical attention?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any prescribed or over-the-counter medication?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Treatment in a hospital or emergency room?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any exposure to a contagious disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____
An illness lasting more than five days?	<input type="checkbox"/>	<input type="checkbox"/>	_____
A surgical operation or fracture?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any restrictions concerning physical activities?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you have any allergies? Yes No
If yes, what is the allergy? _____
What is the reaction? _____

Immunization History
 Are all immunizations current? Yes No
 If not, explain:

- Other health conditions (check those that apply)
- Emotional disturbances
 - Constipation
 - Menstrual cramps
 - Nosebleeds
 - Sleep disturbances
 - Motion sickness
 - Other _____
 - Fainting
 - Hearing impairment
 - Sickle cell trait/disease
 - Special dietary regimen
 - Wear glasses or contacts

Date of last Tetanus _____
 Do you smoke? Yes No
 Do you take medication that might impair your ability to perform the essential functions of your job? Yes No

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be restricted.

This health history is correct and I am able to engage in all prescribed activities except as noted: _____

In case of emergency, if none of the above can be contacted, I consent to treatment for myself under the supervision of and as deemed advisable by a physician licensed under the Medicine Practice Act. This provides authority pursuant to Section 25.8 of the California Civil Code. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

Signature _____ Date _____