PERSONAL HEALTH HISTORY

Community (City/State): _____

Last Name: _____ First Name: _____

Medical Insurance: (company)_Policy Number: _____ Condition of Health:

- ○ Good
- ○ Fair
- ○ Poor
- ○ Other: _____

Do you take any medications on a regular basis ○ No
if yes, complete medication chart on page 2 ○ Yes

Do you have any disabilities or restrictions: ○ No
if yes, describe below ○ Yes

Are you able to participate in a strenuous program? ○ No*
*if no, describe below ○ Yes

Have you ever been in any kind of psychological therapy? ○ No
if yes, describe below (provide additional documentation as necessary) ○ Yes

Check all that apply:

- ☐ None
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bronchitis
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Claustrophobia
- ☐ Contact Lenses
- ☐ Convulsions
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorders
- ☐ Eye Glasses
- ☐ Fainting
- ☐ Frequent Colds
- ☐ GI/Stomach Problems
- ☐ Headaches/Migraines
- ☐ Heart Ailments
- ☐ Kidney Ailments
- ☐ Measles
- ☐ Menstrual Problems (women)
- ☐ Mononucleosis
- ☐ Motion sickness/Vertigo
- ☐ Mumps
- ☐ Neurological Disorders
- ☐ Orthopedic Fractures
- ☐ Psychological Problems
- ☐ Sinusitis
- ☐ Sleep Walking
- ☐ Thyroid Condition
- ☐ Other: _____

NAME: _____

If you checked any of the above, please give all details to each condition (include dates and treatment):

Allergies:
- ☐ None
- ☐ Hay Fever
- ☐ Insect Stings*
- ☐ Medications*
- ☐ Foods*

*List below and reaction:

Medications you will be carrying:

Name of Medication	Take Regularly or As Needed	Dosage & Frequency	Condition Treated	Prescription or Over the Counter

To confirm the information in this document is accurate please sign the separate Authorization Signature Form.