PERSONAL HEALTH-MEDICAL INFORMATION

(Confidential)

Name: ______________________________ Age: ________________

Address: ____

City: __________________________ State: __________ ZIP: ___________

Home Phone: ____________________ Work Phone: ____________________

Medical Insurance Carrier: ______________________________________

Health Condition: _________________ Height: ________ Weight: ________

Medical Date: (Check the appropriate box.)

1. Do you now or have you ever had:

		YES	NO	IF YES, PLEASE EXPLAIN:
a.	Diabetes			
b.	Epilepsy			
c.	Heart problems			
d.	Kidney problems			
e.	Heat stroke			
f.	Frostbite			
g.	Hypothermia			
h.	Excessive nosebleeds			
i.	Sun/snow blindness			
j.	Pulmonary edema			
k.	Altitude sickness			
l.	Asthma			
m.	Ulcers			

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2. Do you have any allergies? ____________________ If yes, please list them and be specific.

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3. Do you smoke? ____

4. List any medical problem(s), illness(es), injury(ies), or chronic condition(s) that you have now or have had in the last three (3) years. Be specific.

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5. List any medications that you are currently taking.

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In Case of an Emergency, provide a contact name and number: