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
- ☐ COVID-19
- ☐ 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.

Please attach copies of your Immunization Record, COVID19 Vaccination Card, front and back of your Medical Insurance Card.