



**Family Physician:**

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

**Insurance Information:**

Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

**Medical History:**

1. Give year of last immunization or booster for Tetanus Toxoid. \_\_\_\_\_

2. Does this participant have any known allergies to:

- Food
- Drugs
- Plants
- Animals
- Insects
- Bee Stings
- Other (list): \_\_\_\_\_

Identify the specific allergy(s): \_\_\_\_\_  
\_\_\_\_\_

3. List any medications (including insulin) currently being taken

Medication: \_\_\_\_\_ used for \_\_\_\_\_  
When taken: \_\_\_\_\_

Medication: \_\_\_\_\_ used for \_\_\_\_\_  
When taken: \_\_\_\_\_

Medication: \_\_\_\_\_ used for \_\_\_\_\_  
When taken: \_\_\_\_\_

4. List any dietary restrictions: \_\_\_\_\_  
\_\_\_\_\_

5. List any physical restrictions: \_\_\_\_\_  
\_\_\_\_\_

6. List any other current health conditions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_