

Adult Health History Form

This health history is to be completed and signed by adult members. (Confidential)

Name	Date of Birth	Age
Address	City	Zip
Position		Troop #
Home Phone	Cell Phone	

In Emergency Notify	Name	Relationship	
Address	City	Zip	Phone #
Name of Family Physician		Physician's Phone #	
Insurance Carrier		Policy or Group No.	

Part 1: Illness and Injuries (check those that apply and give appropriate dates)

Chronic or Recurring Illness

- | | | | |
|---|--|--|-----------------------------------|
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Bleeding/Clotting Disorders | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Hearing Defect/Disease | <input type="checkbox"/> Musculoskeletal Disorders | <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Motion Sickness | |
| <input type="checkbox"/> Other (specify) _____ | | Date of last Tetanus shot or DPT _____ | |

Date of Last Health Examination: _____ Operations or Serious Injuries _____

Were any complicating medical problems noted in last health exam? Yes No

Is adult currently under the care of a physician or psychologist? Yes No

Please explain any "yes" answers to the above questions. _____

Part 2: Allergies (check those that apply and specify nature of allergic reaction)

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Animals _____ | <input type="checkbox"/> Hay Fever _____ | <input type="checkbox"/> Pollen _____ |
| <input type="checkbox"/> Food _____ | <input type="checkbox"/> Medication _____ | <input type="checkbox"/> Plants _____ |
| <input type="checkbox"/> Insect sting _____ | <input type="checkbox"/> Other _____ | |

List any other medical conditions. _____

Part 3: Medications List any prescribed or over the counter medication(s) currently being taken.

Part 4: Other Health Conditions (check those that apply)

- | | | | |
|-------------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Special Dietary Regimen | <input type="checkbox"/> Wears Glasses/Contact Lenses |
| <input type="checkbox"/> Disability | <input type="checkbox"/> Other _____ | | |

Part 5: Immunization History

Immunization	Year Primary Series Completed	Year of Last Booster
DTP		
Diphtheria	_____	_____
Pertussis (whooping cough)	_____	_____
Tetanus	_____	_____
TD		
Measles	_____	_____
Other	_____	_____

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 encouraged or restricted.

This health history is complete and accurate. I am able to engage in all prescribed activities except as noted.

Signature of Adult _____

Date Signed _____