

**HEALTH HISTORY**

**Patient Full Name** \_\_\_\_\_ **Birth Date** \_\_\_\_\_

**Patient Address** \_\_\_\_\_

**Telephone** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_ **Male**  **Female**

Physician Name \_\_\_\_\_

Physician Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Medical Conditions:

- |  |             |  |             |
|--|-------------|--|-------------|
| <input type="checkbox"/> Hypertension                  | Date: _____ | <input type="checkbox"/> HIV/AIDS              | Date: _____ |
| <input type="checkbox"/> Heart Attack or Heart Surgery | Date: _____ | <input type="checkbox"/> Stroke                | Date: _____ |
| <input type="checkbox"/> Hepatitis                     | Date: _____ | <input type="checkbox"/> Diabetes              | Date: _____ |
| <input type="checkbox"/> Angina                        | Date: _____ | <input type="checkbox"/> Special Dietary Needs | Date: _____ |
| <input type="checkbox"/> Pregnancy                     | Date: _____ | <input type="checkbox"/> Other _____           | Date: _____ |

Current Medications (include generic name, strength and dosage):

Blood Type: \_\_\_\_\_

Medical Conditions Requiring Doctor's Approval:

- Asthma
- Cardiac condition
- Hepatitis A or C
- Insulin dependent diabetes
- Pulmonary condition
- Seizure disorders
- History of deep vein thrombosis
- Recent surgery or other invasive procedure
- Recent infection, e.g., pneumonia, bronchitis, etc.

Medical Conditions Prohibiting Participation:

- Hepatitis B
- HIV
- Pregnancy
- Tuberculosis

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

Please feel free to give additional comments on the reverse side of this Health History form.

\*This form must be submitted with your application. \*