

# Participant Medical Information

Please provide the following. All areas must be completed.

Your Full Name: \_\_\_\_\_

## Illnesses & Medical Issues

Please list all conditions you have had and/or been treated for:

	Yes	No		Yes	No
Asthma	___	___	Diabetes	___	___
Bleeding Disorders	___	___	High Blood Pressure	___	___
Cancer	___	___	Migraine headaches	___	___
Colitis	___	___	Ulcers	___	___
Epilepsy	___	___	Heart Disorder	___	___
Anxiety/Depression	___	___	Pregnant	___	___

Other illnesses or physical restrictions related to the above: \_\_\_\_\_

\_\_\_\_\_

## Injuries

	Yes	No		Yes	No
Head injury	___	___	Recurrent ankle injury	___	___
Sprained back	___	___	Recurrent knee injury	___	___
Broken Bones	___	___	Other: _____		

Date of last Tetanus shot: \_\_\_\_\_

## Medications

Please list all current medications you are taking. Indicate the name, amount (dose) and how often you are taking it.

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Allergies

Please list any allergies you have: \_\_\_\_\_

\_\_\_\_\_

## Dietary

Please list any special dietary requirements (other than vegetarian) that you observe:

\_\_\_\_\_

Name of Your Medical Insurance Co: \_\_\_\_\_

Policy Number: \_\_\_\_\_