EXPLORING™
DISCOVER YOUR FUTURE

GENERAL HEALTH INFORMATION HISTORY

PERSONAL INFORMATION

Full Name :

Date Of Birth : / / **Gender** : ☐ Male ☐ Female

Height (feet) : **Weight (lbs)** :

Address :

City : **State**: **Zip Code** :

Phone Number : **E-Mail** :

Health/Accident Insurance Company: **Policy Number** :

EMERGENCY CONTACT DETAILS

Contact Name : **Phone Number** :

Relationship : **Other Phone** :

ALLERGIES/MEDICATIONS

Do you use an epinephrine autoinjector? : ☐ Yes ☐ No

Do you use an asthma rescue inhaler? : ☐ Yes ☐ No

Are you allergic to or do you have any adverse reaction to any of the following:

Medication : ☐ Yes ☐ No **Explain** :

Food : ☐ Yes ☐ No **Explain** :

Plants : ☐ Yes ☐ No **Explain** :

Insect bites/Stings : ☐ Yes ☐ No **Explain** :

List all medications currently used

Please list any additional information about your medical history