

Team Member Medical History Form

Full Name: _____ DOB: _____
Employer: _____ Occupation: _____

Emergency Contacts:

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

Medical Conditions:

Please check if you currently have or have had any of the following:

<input type="checkbox"/> Asthma <input type="checkbox"/> Hypertension <input type="checkbox"/> Depression <input type="checkbox"/> Psychiatric Disorder	<input type="checkbox"/> Hepatitis B <input type="checkbox"/> Seizures <input type="checkbox"/> Blood Clots <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Heartburn <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Ulcers <input type="checkbox"/> Hay Fever	<input type="checkbox"/> Migraines <input type="checkbox"/> Elevated Cholesterol <input type="checkbox"/> Urinating Difficulties <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Cancer
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☐ other - please explain: _____

Immunizations:

Immunizations: Last Tetanus: ____/____/____	Covid - 19 ____/____/____	Hepatitis B Series: ____/____/____
Hepatitis A Series: ____/____/____	Flu: ____/____/____	Whooping Cough : ____/____/____

Medications: List medications and dose you are currently taking. Include vitamins and herbal supplements.

Check if there are no medications. ☐

Allergies:

Check if there are no allergies. ☐

Please list any past surgeries/hospitalizations and year:

Check if there are none. ☐

Other:

Tobacco Use? <input type="checkbox"/> Yes <input type="checkbox"/> No packs/day _____ Former Tobacco User? <input type="checkbox"/> Yes <input type="checkbox"/> No date quit _____ Alcohol Use? <input type="checkbox"/> Yes <input type="checkbox"/> No drinks/week _____	Recreational Drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No times/week _____
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Envelope Permission Statement

Name: _____ Date: _____

Check one:

_____ If I am found in an altered state **anyone on the team can open the envelope** and relay information to 911 and responding emergency medical personnel.

_____ If I am found in an altered state please **give to responding emergency medical personnel**.

Signature

Anyone opening the envelope without permission will be in violation of The Health Insurance Portability and Accountability Act of 1996 (HIPAA).



PLACE THIS CUTOUT ON THE FRONT OF AN ENVELOPE, HAVE MEMBER SEAL
ENVELOPE THEMSELVES

Name: _____ Date: _____

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