advisor health history
please remove from brochure

Name:_____
Last First Middle

Name of School or Organization: _____

Name of Family Physician or Clinic: _____

Address: _____
Street Town State

Phone: _____

Date of last Tetanus or Booster shot: _____

Do you have any known allergies to medications or foods? Yes No If Yes, please list.

Product / Item	Reaction
_____	_____
_____	_____

Are you diabetic? Yes No **Are you hypoglycemic? Yes No**

If you answered yes to either of these questions, please answer the following.

Do you take insulin? Yes No

Type _____ Dosage _____ Times _____

Do you take oral glycemics? Yes No

Type _____ Dosage _____ Times _____

Do you have any dietary restrictions? Yes No If Yes, please list.

_____

Have you ever, or do you currently have, any of the following conditions / illnesses?

Asthma	Yes	No	High Blood Pressure	Yes	No
Blackouts	Yes	No	Migraines	Yes	No
Dizziness	Yes	No	Respiratory Problems	Yes	No
Epilepsy	Yes	No	Seizures	Yes	No
Fainting Spells	Yes	No	Sickle Cell Anemia	Yes	No
Heart Disease	Yes	No			

Any other medical conditions? Yes No

If yes, please explain._____

Are you currently under medical care? Yes No

If yes, please explain._____

Will you be on any medications during the conference? Yes No If yes, please list.

Name _____ Dosage _____ Reason _____

Name _____ Dosage _____ Reason _____

Do you wear contact lenses? Yes No

Please describe any other medical information that we should know about.:

_____