# HEALTH HISTORY


**Please Print- To be completed by the applicant.**

**Last Name** _____ **First Name** _____

**Address** _____

**City** _____ **Region/State** _____ **Zip Code** _____

**SSN** _____ **Age** _____ **Birthdate** _____

**Gender** ____**Male** ____**Female** **E-Mail** _____

**Cell Phone** _____

| | | | |
|---|---|---|---|
| Height | Weight | History of seizures<br>When:<br>Medication | Diabetesl1 or 2<br>Medication: |
| Special Medical Needs or attentions: | Allergies:<br>Reactions:<br>Medication: | Multiple Sclerosis:<br>Medication: | High Blood Pressure<br>Medication: |
| History of heart attacks/strokes<br>When:<br>Medication: | Eye sight<br>Any eye disease: | Respiratory: | Communicable Diseases: |
| Anything that we should be aware of? | Any Physical limitations that would make it difficult for you to attend CFNIB? | Explain limitations: | Other: |

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Emergency Doctor's Name _____

Address _____

Work Phone Number _____ Cell Phone _____

E-Mail _____

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