

VOLUNTEER HEALTH HISTORY FORM

This form is to help the Employee Health Department give you better health care. This information is confidential. It will be part of your volunteer medical record.

Name _____ Date of Birth _____

MEDICAL HISTORY Check Appropriate Box

Neurologic Severe or Migraine Headaches Severe Dizziness Blackout/Fainting Spells	Past ___ ___ ___	Now ___ ___ ___	Never ___ ___ ___	Blood System High or low Blood Sugar (Diabetic)	Past ___ ___ ___	Now ___ ___ ___	Never ___ ___ ___
Chest and Lungs Chronic Lung Disease Bronchitis Emphysema Pneumonia	Past ___ ___ ___ ___	Now ___ ___ ___ ___	Never ___ ___ ___ ___	Eyes Do you wear Glasses or Contacts?	Yes ___ ___ ___	No ___ ___ ___	
Cardiovascular (heart) Heart pain at rest Heart pain on exertion (Angina) Radiation of pain to Arms, Jaw, or Back Fast Pulse Irregular Heartbeat	Past ___ ___ ___ ___ ___ ___	Now ___ ___ ___ ___ ___ ___	Never ___ ___ ___ ___ ___ ___	High Blood Pressure Heart Attack	Past ___ ___	Now ___ ___	Never ___ ___
				Ears Do you wear a Hearing Aid?	Yes ___	No ___	

List Medications/Drugs you have taken the past three months:

Do you currently have physical limitations? Yes _____ No _____
 If yes, Describe:

Any other Allergies?

 Signature of Patient

 Date