Volunteer's Full Name ____ Date of Birth: _________________

Mountain Valley Adult Health History & Consent to Treat

Medical History: check all that apply

	Arthritis		*Hearing Impairment*		*Surgery/Hospitalized in last 5 years*
	Asthma		*Speech Impairment*		Menstrual cramps
	Bleeding disorder		*Heart Defects /Disease*		*Musculoskeletal Disorders*
	Convulsions/Epilepsy/Seizures		*Hernia*		*Mental/Psychological Disorders*
	Diabetes		*Hypertensions/High Blood Pressure*		*Nosebleeds*
	Diseases of the Ear / Infections		*Intestinal Disorders/Constipation*		*Sinusitis (Sinus Infections)*
	Eating Disorders (Anorexia, Bulimia, etc)		*Eyesight impairment*		*Sleep Impairment*
	Fainting/dizzy spells		*Currently under Physician/Psychologist Care*		*Wears glasses, contacts or protective eyewear*
	Headaches/Migraines		*Kidney/bladder illness*		*Rheumatic Fever*
	Chicken Pox		*German Measles*		*Other:*
	Measles		*Mumps*		*Other:*
	Tuberculosis		*Kidney Disease*		*Other:*

Please explain in detail any checked items above:

Date of last health examination: _________ Were any complicating medical problems noted in the last health exam? ____ Yes ____ No

Are all immunizations current? ____ Yes ____ No DTP or DT (Tetanus) Date _______
If not, state reason(s):

Medical Conditions and/or Concerns

Please include any precautions or restrictions on activities, as well as concerns relating to emotional and mental wellbeing (including self-harm, depression, effects of medication on their behavior, eating disorders, etc.).

Name of Condition	Effects

Additional Information or Comments:

Volunteer's Full Name ____ Date of Birth: __________________

Allergies - List ALL allergies (including medications, food, bees, etc.)

Allergies	Reaction/Severity	Treatment	Date of Last Reaction

Comments:

Do you suffer from anaphylaxis?* ____ Yes ____ No
*A severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.
Do you carry an Epipen? ____ Yes ____ No Do you carry an inhaler? ____ Yes ____ No

Have you ever had any adverse reactions to general anesthetics? ____ Yes ____ No

Prescribed Medications *Use the back of this page or a separate page to list additional medications:

Medication	Purpose	Dosage	Special Instructions

Notes:

Health Care Providers:

	Volunteer's Physician	Volunteer's Dentist
Name		
Phone		

Medical Insurance Information:

Insurance Company		Group/Policy Number	
Insurance Co Phone Number		Subscriber's Name	

Include a copy of your insurance card if appropriate; copy both sides so the information is able to be read.

Emergency Contact Information:

Name	Emergency Contact #1	Emergency Contact #2
Cell Phone		
Alternate Phone		
Relationship to Volunteer		