PARTICIPANT'S MEDICAL HISTORY

Full name ....

Emergency contact person & phone number(s): ....

....

Are you under treatment for any illness or condition? ....

Are you currently taking any form of medication? ....

Do you have any allergies? ....

Do you have any disabilities? ....

Do you have any past injuries? ....

Do you have any history of heart problems? ....

If you indicated **yes** on any of the above please describe and discuss any limitations

....

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Please circle any of the following **ILLNESSES** you have had and give the year of occurrence:

Arthritis	________	Diabetes	________	Malaria	________	Poliomyelitis	________
Asthma	________	Epilepsy	________	Measles	________	Rheumatic Fever	________
Gall Bladder Disease	________	Meningitis	________	Tuberculosis	________	Colitis	________
Heart Disease	________	Mononucleosis	________	Typhoid	________	Convulsions	________
Hepatitis	________	Black outs	________	Other	________________________		