

Signature of Applicant ___

Adult Health History Form

Session Name						_ Dates _		
Personal Information - Please com	olete the	following:						
Name (Last, First, Initial)						Sex	Bir	th Date
Address	City o	r Town	State	Zip		Phone		
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In Emergency, Notify Name	Addre	ess		Relat	tionship	,	Ph	one
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In Emergency, Notify Name	Addic			Ttola	попопір		()
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Insurance Information - Please con	nplete the							
Carrier		ID Number			Gro	up Number		
Member Services Phone Number		Address						
()								
Health History - Please check if you	have had	d any of the followi	ng:					
☐ Vision Impairment		Kidney Disease			nritis			Disease of Ears
Hearing Impairment		Heart Disease Rheumatic Fever			betes			Intestinal Disorders
Speech ImpairmentNervous System Disorder		Rneumatic Fever Abnormal Blood Pres		⊒ Tuk ⊒ Hei	perculosis mia			Chicken Pox Measles
☐ Sinusitis		Mental or Emotional I			hma or Ha	y Fever		Mumps
■ Lyme Disease		Severe Menstrual Pa	in [☐ Oth	er Serious	Allergies		German Measles
□ Other	_							
☐ Other								
Date of Tetanus Shot (MM/YY):			0	Aro ve	ou taking	any modica	otion?	□ Vos. □ No.
Date of Tetanus Shot (MM/YY): Have you been hospitalized in the last fire	ve years?	? □ Yes □ N		-	-	-		☐ Yes ☐ No
Date of Tetanus Shot (MM/YY):	ve years?	? ☐ Yes ☐ N the above, please	give the followin	ng infoi	mation (U	Jse back of		
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