CONFIDENTIAL

Member Health History Questionnaire
For Emergency Medical Use ONLY

Date Completed: ________________ **SUPERCEDES ALL EARLIER-DATED FORMS**

All questions contained in this questionnaire are strictly **confidential** and will be used **ONLY** to guide your medical treatment in an emergency.

Name: ☐ M ☐ F	**Age**: _____	**DOB**: / /	
Address:	**City:**	**State:**	**Zip:**

In An Emergency, Contact the following, in the Order Listed:

1. Name:	**Relationship:**	**Phone #1:**	**Phone #2:**	**Phone #3:**
2. Name:	**Relationship:**	**Phone #1:**	**Phone #2:**	**Phone #3:**
3. Name:	**Relationship:**	**Phone #1:**	**Phone #2:**	**Phone #3:**

PERSONAL HEALTH HISTORY

Illnesses (Check any that apply)

☐ High Blood Pressure	☐ Hepatitis B or C
☐ Coronary Artery or Heart Disease	☐ Gall Stones/Gall Bladder Surgery
☐ Cardiac Arrhythmia (irregular heart rhythm)	☐ Irritable Bowel Syndrome (IBS)
☐ Heart Murmur	☐ Inflammatory Bowel Disease (Crohn's, UC)
☐ Heart Valve Abnormality	☐ Gastric Reflux/GERD
☐ Asthma/ Bronchitis	☐ GI Ulcer (esophageal, gastric or duodenal)
☐ Seasonal Allergies	☐ Frequent Urinary Tract Infections (Bladder or Kidney)
☐ Anemia	☐ Kidney Stones
☐ Blood Disease/Disorder	☐ Multiple Sclerosis
☐ Deep Venous Thrombosis	☐ Cancer or Tumor; Type:
☐ Fibromyalgia	☐ Depression
☐ Loss of Consciousness/ Head Injury	☐ Anxiety
☐ Seizures	☐ Eating Disorder
☐ Thyroid Disorder (hypothyroid, hyperthyroid, Hashimoto's or Graves)	☐ Bipolar Disorder
☐ Diabetes Type 1 (last HBA1C =)	☐ Obsessive Compulsive Disorder (OCD)
☐ Diabetes Type 2 (last HBA1C =)	☐ Overtraining Syndrome
☐ Systemic Lupus Erythematosus (SLE)	☐ ADD/ADHD
☐ Rheumatoid Arthritis	☐ Alcohol/Substance Abuse
☐ Chronic Fatigue Syndrome	☐ Frequent Severe Headaches/Migraines

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Name:	**Age:**	**DOB:** / /

List any other medical conditions not specified above:

1. ____________________
2. ____________________
3. ____________________

Surgeries / Hospitalizations or Inpatient treatment

Year	Reason	Hospital

List ALL medications (include prescriptions, over-the-counter medications, vitamins, supplements, herbal remedies, etc.)

Name of Drug / Supplement	Strength (mg, etc)	Times per Day	Start Date/Year	Prescribed By
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	

Allergies to medications, foods, or others (latex, insect bites, environmental)

Name	Reaction_You_Have_if_Exposed_to_this_Substance

CERTIFICATION

The above information is true to the best of my knowledge.

X ____________________ ____________________
Patient (Signature) Date

X ____________________ ____________________
Legal Guardian/Authorized Individual Signature (Required if under 18 years of age) Date