

HEALTH AND MEDICAL RECORD

The health care information is confidential and strictly for the use of the Lynchburg College Outdoor Leadership Program. It will not be released to anyone without your consent. Please print so other can read your writing.

_____	_____	_____
Last Name	First Name	Middle
_____		() _____
Home Address (Number & Street) City or Town State Zip Code		Home Phone #
_____		() _____
Emergency Contact Name (Parent or Guardian if under 18)		Home Phone #
_____		() _____
Emergency Contact Address (Parent or Guardian if under 18)		Emergency Phone #
Do You Have Health Insurance <input type="radio"/> No <input type="radio"/> Yes		() _____
_____		Phone #
Health Insurance Company Address		

Name of Insured Policy Number

PERSONAL MEDICAL HISTORY FOR PRE-EXISTING CONDITIONS (Please use the back of this form if needed)

Please list your ALLERGIES to: _____ and _____ and _____

Medications _____ Used for _____

Environmental _____

Other _____

Please list any illness or medical condition for which you are being treated.

Condition Year Diagnosed Treatment

Condition Year Diagnosed Treatment

Please list any operations or hospitalizations you have had.

Reason Hospital Doctor Date

Reason Hospital Doctor Date

Please list all medications you are now taking to treat (potential) medical conditions.

Name of Medication Dose How Often

Name of Medication Dose How Often

Name of Medication Dose How Often

Name of Medication Dose How Often

Please rate your current level of physical activity

Times Per Week

Times Per Week

Times Per Week

Walking

1-2

3-5

5+

N/A

Jogging

1-2

3-5

5+

N/A

Cycling

1-2

3-5

5+

N/A

Aerobics

1-2

3-5

5+

N/A

General Sports

1-2

3-5

5+

N/A

Swimming Ability

Beginner

Intermediate

Advanced

None

PLEASE ANSWER ALL QUESTIONS: YES OR NO	Yes	No	Have you ever had	Yes	No
Have you ever had...					
Anemia			Irregular Heart Beat		
Asthma			Kidney Problems		
Bleeding disorder			Mononucleosis		
Cancer			Orthopedic Injury		
Chest pains			Palpitations (heart)		
Complete/partial hearing loss			Pneumonia		
Concussion			Recurrent headaches (migraines)		
Diabetes			Rheumatic heart disease		
Elevated cholesterol			Seizures		
Head injury (unconsciousness)			Stomach (ulcers)		
Heart murmur			T.B. (or exposure)		
Heat related illness			Thyroid problems		
Hemorrhoids/rectal bleeding			Do you smoke?		
Hepatitis			Ever feel dizzy or faint during exercise		
Hernia			Shortness of breath with or w/o exercise		
Intestinal problems			Ever told not to participate in sports?		
Orthopedic injury					

Revised 11/5/2010