# Participant Medical History Form

## 2018 Real Voices Real Choices

The completion of this form is optional; however, please note that in the case of a medical emergency ***this information would be critical*** to ensure that you receive the most appropriate medical care.

**Participant Name:** _____ **Age:** _____

**Name of Emergency Contact:** _____

**Emergency Contact Phone Number:** _____

**Alt. Phone Number:** _____

| Allergy Questions | | |
|---|---|---|
| **Do you have any allergies?** | **Yes** ☐ | **No** ☐ |
| **Medication Allergies?** | | |
| **Food allergies?** | | |
| **Other allergies?** | | |

| General Health Questions | | | |
|---|---|---|---|
| **Do you have any ongoing medical conditions?** | **Yes** ☐ | **No** ☐ | |
| Please specify below: | | | |
| **Asthma** ☐ | **Diabetes** ☐ | **Seizures** ☐ | **Heart condition** ☐ |
| **High Blood Pressure** ☐ | | | |

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|---|
| **Other medical conditions?** |
| **Have you been hospitalized within the last year?** Yes ☐ No ☐ |
| If yes, for what? |
| **Do you wear glasses or contacts?** Yes ☐ No ☐ |
| **Do you wear hearing aids?** Yes ☐ No ☐ |
| **Please describe the assistive devices you use** (i.e. wheelchair, toilet riser, grab bars, etc.)**:** |

| Current Medications | | | | | |
|---|---|---|---|---|---|
| **Medication Name** | **Dose** | **How often** | **Medication Name** | **Dose** | **How often** |
| | | | | | |
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