The First Congregational United Church of Christ of Appleton, Wisconsin

Adult Health Information Form

General Information

Date_____

Name _____
First Middle Last

Gender_____ Birth date_____

Address_____
Street City State Zip Code

Home phone_____ Cell phone_____

Email_____

Emergency contact_____

Address_____
Street City State Zip Code

Home phone_____ Cell phone_____

Health Insurance

Do you have health insurance? (check one) Yes ☐ No ☐

Hospital/health insurance company_____

Policy number_____

Coverage in the name of_____

****Please attach a copy of your insurance card to this form.**

Health Information

Family physician_____

Office phone_____

Year of last tetanus booster_____ Are you pregnant?_____

Medication

Are you bringing any medications? (check one) Yes ☐ No ☐

If yes, what are they and what is their schedule and dosage? All medications must be in their original containers (even aspirin or over-the-counter medications). Each must contain the name, original orders, dosage, dates, directions for use and specifics for special storage (such as refrigeration needed).

List of Medications (include prescriptions and over-the-counter medicines, reason for medication, dosage, and times to be dispensed

_____

_____

_____

_____

_____

Diet Restrictions

_____

_____

_____

Allergies

(Place a X on all that apply and specify nature of the allergic reaction.)

Food Allergies

____Peanuts
____Tree nuts
____Wheat (Celiac)
____Soy
____Fish
____Shellfish
____Dairy
____Eggs

Drug Allergies

____Penicillin
____Anticonvulsants
____Insulin
____Iodine
____Sulfa drugs

Environmental Allergies

____Animals
____Dust
____Outdoor/Seasonal
____Mold
____Latex

Other allergies_____

Nature of the reactions_____

_____

_____

Medical Concerns

Have you had or do you have any of the following? (If yes, please explain.)

	Yes	No	Explanation
Anemia	____	____	_____
Arthritis	____	____	_____
Asthma	____	____	_____
Attention deficit	____	____	_____
Autism/Asperger Syndrome	____	____	_____
Autoimmune Disease	____	____	_____
Diabetes	____	____	_____
Difficulty breathing	____	____	_____
Epilepsy or seizures	____	____	_____
Heart disease/conditions	____	____	_____
Hepatitis	____	____	_____
HIV	____	____	_____
High or low blood pressure	____	____	_____
Joint conditions	____	____	_____
Joint replacements	____	____	_____
Mental health conditions	____	____	_____
Rods, pins or plates in body	____	____	_____
Thyroid problems	____	____	_____
Other medical concerns	____	____	_____