Confidential Medical History Form

Providing long-term mentoring to underserved youth through wilderness programs focused on leadership, stewardship and unity.

All personal health information provided in this questionnaire is strictly confidential and will only be shared, in emergency situations, with medical professionals.

Complete and return to: WYLD PO Box 26171, Los Angeles, CA 90026 Phone: (310) 614 – 6678 Email: Chris@wyld.org

Part I: General Information

Participant Name: _____ Address _____ Apt. _____

Gender: ☐ Male ☐ Female City/State/Zip _____

Age: _____ DOB: _____ SS#: _____ Daytime Phone _____

Height _____ ft. _____ ins. _____ Weight _____ lbs. Evening Phone _____

Email: _____ Cell Phone _____ Fax _____

Parent / Guardian / Emergency Contact: Address _____

Name: _____ Daytime Phone _____

Relationship: _____ Evening Phone _____

Email: _____ Cell Phone _____ Fax _____

Does the Participant Have Health Insurance? ☐ Yes ☐ No Date of Last Physical Exam: _____

Provider: _____ Policy/Certificate#: _____

Prescription Plan #: Telephone: _____

Part II: Participant Health History (Past and Present Medical Information)

A. Medical Conditions (Please check all that apply to you)

Yes or No	Yes or No	Yes or No
☐ ☐ High blood pressure	☐ ☐ Endocrine problem	☐ ☐ Cancer
☐ ☐ Heart disease	☐ ☐ Hearing impairment	☐ ☐ Genetic defects
☐ ☐ Irregular heartbeat	☐ ☐ Vision Impairment	**Do you currently or regularly have any of the following symptoms?**
☐ ☐ Positive TB test	☐ ☐ Sleep disorder	☐ ☐ Chest pain/pressure
☐ ☐ History of hepatitis	☐ ☐ Broken bones (in past 18 mos)	☐ ☐ Shortness of breath
☐ ☐ Seizure disorder/epilepsy	☐ ☐ Neck problem	☐ ☐ Dizziness
☐ ☐ Bleeding disorder	☐ ☐ Back problem	☐ ☐ Fainting
☐ ☐ Blood disorder/anemia	☐ ☐ Shoulder problem	☐ ☐ Muscle cramps
☐ ☐ Sickle cell trait	☐ ☐ Knee problem	☐ ☐ Intolerance to warm/cold
☐ ☐ Chronic cough	☐ ☐ Leg or hip problem	☐ ☐ Altitude Problem
☐ ☐ Asthma	☐ ☐ Elbow/wrist/hand problem	**Do any of the following mental health issues apply to you?**
☐ ☐ Diabetes	☐ ☐ Ankle problem	☐ ☐ Depression
☐ ☐ Hypoglycemia (low blood sugar)	☐ ☐ Foot problem	☐ ☐ Anxiety
☐ ☐ Frostbite	☐ ☐ Osteoarthritis	☐ ☐ Eating disorder
☐ ☐ Heatstroke	☐ ☐ Gout	☐ ☐ Schizophrenia
☐ ☐ Circulation problem	☐ ☐ Current pregnancy	☐ ☐ Psychotic disorder
☐ ☐ Neurological impairment	☐ ☐ Dyslexia	☐ ☐ Self-harming behavior
☐ ☐ Gastrointestinal problem	☐ ☐ ADHD	☐ ☐ Alcohol or drug abuse
☐ ☐ Genitourinary problem	☐ ☐ Severe infections	☐ ☐ Bipolar disorder

If you checked any conditions above, please provide detailed descriptions below. Include specific symptoms, duration, preventative or managed care and date of last occurance. Please list any symptoms/conditions that restrict physical activity in any way (include ability to run, lift, climb).

Condition	Description

B. Participant Childhood Illnesses (Please check the appropriate boxes)

☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox ☐ Polio ☐ Rheumatic Fever

Other: _____

C. Immunizations and Dates (Please check the appropriate boxes)

☐ Tetanus	_____	☐ Pheumonia	_____
☐ Hepatitis	_____	☐ Chicken Pox	_____
☐ Influenza	_____	☐ MMR	_____

Other: _____

We recommend that all employees have a current tetanus immunization (within 10 years) and other immunizations as appropriate to the working environment.

D. Participant Allergies (include allergies to medicines, insect bites/stings)

Allergy	Reaction	Medication Required
Food Allergies:		

E. Participant Current Medications (List any you are currently using or have been taking within the last two months. Include over-the-counter drugs, inhalers and herbal supplements)

Medication	Taken for (symptoms/condition)	Dosage	Date Started	Side Effects (if any)

F. Participant Hospitalizations/Emergencies/Urgent Care (Please list any hospital, emergency department or urgent care visits with last two years)

Date of Visit/Admittance	Reason	Length of Stay

G. Participant Blood Pressure (Blood pressure must be taken within 60 days of course start. It can be taken for free at local department or drug stores)

Do you have a history of High Blood Pressure? ☐ **YES** ☐ **NO**

Blood Pressure Reading _____ / _____ Date Taken _____

If your Blood Pressure is higher than 150/90, a second reading will be needed.

Blood Pressure (Second Reading) _____ / _____ Date Taken _____

H. Health Habits

Exercise:	☐ Sedentary (no exercise) ☐ Mild exercise (climb stairs, frequent walks, golf) ☐ Occasional vigorous exercise (less than 3 times per week for 30 minutes) ☐ Regular vigorous exercise (more than 3 times per week for 30 minutes)
Diet:	Are you currently dieting? ☐ Yes ☐ No Are you on a physician-prescribed medical diet? ☐ Yes ☐ No

Signature:

All information will remain confidential. Failure to disclose information could result in harm to the program participant. By signing this form, you are acknowledging that the **LA WYLD** may request from you access to those medical records that are relevant to your participantion with us.

By signing this document, I hereby give permission, in the event of an emergency, for any emergency anesthesia, operation, hospitalization or other treatment that may be, in the judgment of a healthcare provider, necessary. I certify that this medical record is complete and accurate to the best of my knowledge and that I have made no attempt to conceal information.

_____ _____

Particpant Signature **Date**

_____ _____

Parent / Gaurdian Signature **Date**