

**Medical History**  
(Travel Folder)

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

1. Do you have or ever had:
- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. Asthma  | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| b. Diabetes                                      | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| c. Epilepsy                                      | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| d. MRSA  | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| e. Cardiac Problems (heart murmur, syncope, etc) | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| f. Lung Problems                                 | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| g. Head Injury (Concussion)                      | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| h. Chronic Headaches (Migraines)                 | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| i. Heat Illness (cramps, exhaustion, etc)        | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| j. Circulation Complications (Reynaud's, etc.)   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| k. Neurological Problems (Spinal, Sciatica)      | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

If yes to any please explain:

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2. Are you taking any medications? YES  NO   
If yes, list Medication and Dosage:

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3. Are you allergic to any medications? YES  NO   
4. Other Allergies (bees, etc) YES  NO

If yes explain:

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