girl scouts in the heart of pennsylvania

Health History Form – Adult

Personal Information

Name _____ Birth Date _____

Address _____

City _____ State _____ Zip Code _____

( ) _____ ( ) _____

Phone Other Phone

Emergency Contact Information

Name _____

( ) _____ ( ) _____

Phone Other Phone

Name _____

( ) _____ ( ) _____

Phone Other Phone

Physician Information

Name _____ ( ) _____

Phone

Medical/Hospital Insurance Carrier _____ Policy/Group Number _____

Date of last health exam _____ Are activities restricted? □ Yes □ No If yes, please explain. _____

Health History

I. Allergies: Check all that apply and elaborate if necessary.

☐	Animals		☐	Plants	
☐	Food		☐	Pollen	
☐	Insect bites/stings		☐	Medicine	
☐	Hay Fever		☐	Other	

II. Chronic/Recurring Conditions: Check all that apply.

☐	Asthma/Respiratory Problems	☐	Epilepsy	☐	Seizures
☐	Kidney Disease	☐	Headaches	☐	Constipation
☐	Musculoskeletal Disorders	☐	Fainting	☐	Hearing Impairment
☐	Sickle Cell Trait or Disease	☐	Nosebleeds	☐	Emotional Disturbances
☐	Ear Infections	☐	Bleeding/Clotting Disorders	☐	Diabetes
☐	Dietary Restrictions	☐	Hypertension	☐	Heart Disease

☐ Other _____

III. Check if you wear any of the following:

☐ Contact Lenses ☐ Glasses ☐ Dental Appliance ☐ Other _____

Please see reverse side.

Girl Scouts in the Heart of Pennsylvania | 350 Hale Avenue | Harrisburg, PA 17104 | 800.692.7816 | general@gshpa.org

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Health History Form – Adult

Please List All Current Medications

Signature: _____ Date: _____

FOR OFFICE USE ONLY	
Date Received:	Initials:

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