

# SOUND EXPERIENCE – Medical Health History Form

Sound Experience · PO Box 1390 · Port Townsend, WA 98368 · (360) 379-0438 · Fax: (360) 379-0439

Please return to office ONE MONTH prior to voyage

Name \_\_\_\_\_ Gender \_\_\_\_\_ Today's Date \_\_\_\_\_  
Family Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Family Medical/Hospital Insurance Carrier: \_\_\_\_\_ Policy # \_\_\_\_\_

## Part I: Illnesses and Injuries (check all that apply and give appropriate dates)

Please indicate all Chronic or Recurring Illnesses:

\_\_\_\_\_ Ear Infection                      \_\_\_\_\_ Bleeding/Clotting Disorders                      \_\_\_\_\_ Hypertension                      \_\_\_\_\_ Asthma  
\_\_\_\_\_ Heart Defect/Disease                      \_\_\_\_\_ Musculoskeletal Disorders                      \_\_\_\_\_ Seizures                      \_\_\_\_\_ Diabetes  
\_\_\_\_\_ Other (specify) \_\_\_\_\_

Date of last health examination: \_\_\_\_\_

Describe any complicating medical problems noted in last health exam: \_\_\_\_\_

Is participant currently under the care of a physician or psychologist? \_\_\_\_\_

Please indicate all conditions participant has had since her/his last health exam:

- A serious injury requiring medical attention                       Any prescribed or over-the-counter medication  
 Treatment in a hospital or emergency room                       Any exposure to contagious diseases  
 Any restrictions concerning physical activities

Please explain details of all conditions indicated above: \_\_\_\_\_

## Part II: Allergies (check those that apply and specify nature of allergic reaction.)

Animals \_\_\_\_\_                       Hay Fever \_\_\_\_\_                       Pollen \_\_\_\_\_  
 Food \_\_\_\_\_                       Medicines/drugs \_\_\_\_\_                       Insect Stings \_\_\_\_\_  
 Plants \_\_\_\_\_                       Other \_\_\_\_\_

## Part III: Other Health Conditions (check all that apply)

Bed Wetting                       Emotional Disturbances                       Constipation                       Menstrual Cramps  
 Hearing Impairment                       Motion Sickness                       Sickle Cell Trait or Decease                       Nosebleeds  
 Special Dietary Regimen                       Sleep Disturbances                       Glasses or Contact Lenses                       Fainting

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted: \_\_\_\_\_

**Drugs / Prescriptions:** Medications MUST be in the original container and labeled for the participant. No minors will be permitted to carry medication unless written permission is given. Please list all medications to be brought on board:

<b>Current Medications:</b>	<b>Amount /Frequency Administered:</b>	<b>Purpose:</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Part IV: Immunization History (Diphtheria, Pertussis, Measles, Mumps, Rubella, Oral polio, Hbpy)

Date of last Tetanus shot \_\_\_\_\_ Date of most recent Tuberculin test \_\_\_\_\_

Other: \_\_\_\_\_