HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential

Original Date: **Revised Date:**

Name*: Last, First, MI* _____ **DOB:** _____

ADDRESS: *(street & Apt)*_____

*(City, State, Zip)*_____

Emergency Contact(s): Name: Phone Number(s):

Physician: Name: Phone Number(s):

Medical Insurance:	Policy #:

Immunizations: Tetanus: ☐ Date: Other: ☐ Date:
Other: ☐ Date: Other: ☐ Date:
Other: ☐ Date: Other: ☐ Date:

List any medical problems that doctors have diagnosed:

List your prescribed drugs and over-the-counter medications: add on to back of page as needed

Drug Name:	Strength:	Frequency Taken:

Explain any allergies to medications:	
Drug Name:	Reaction you had:
Drug Name:	Reaction you had:
Drug Name:	Reaction you had:
Drug Name:	Reaction you had:

It is mandated that an updated copy of this form be submitted to the Unit Secretary for the entire reenactment season and that an updated copy be kept on your person at each event. For additional information regarding proper placement of this form, please contact a member of Field Command