



Girl Scouts of Kentucky's Wilderness Road Council

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Adult Health History Record

Name _____

Name of family physician _____ Phone (____) _____

Family medical/hospital insurance carrier _____ Policy or Group No. _____

Part I: Illness and Injuries (Check those that apply and give appropriate dates.)

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

Date of last health examination _____

Were any complicating medical problems noted in last health examination? _____

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

- Animals _____
- Pollen _____
- Medicines/Drugs _____
- Plants _____
- Hay Fever _____
- Food _____
- Insect Stings _____
- Other (specify) _____

Part III: Other Health Conditions (Check those that apply.)

- Constipation
- Hearing Impairment
- Motion Sickness
- Wear Glasses (Contact Lenses)
- Sickles Cell Trait of Disease
- Other (specify) _____
- Emotional Disturbances
- Special Dietary Regimen
- Nose Bleeds
- Sleep Disturbances
- Menstrual Cramps
- Fainting

Part IV: Immunization History

Immunization	Year Primary Series Completed	Year of Last Booster
D.T.P. (Diphtheria, Tetanus, Pertussis-whooping cough)	_____	_____
Td	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella (German measles)	_____	_____
Oral Polio	_____	_____
Hib	_____	_____
Tuberculin Test (most recent)	_____	Result _____
Other _____	_____	_____

Please explain any items that are checked in relation to any of these health conditions.

Signature _____ Date _____