Medical History Form

ParanormalSafety.com
A safe investigation is a happy investigation

Name: ____ DOB: ___________________________
Employer: ______________________________ Occupation:_____________________________________

Emergency Contacts:
Name: ________________________________ Phone: _________________Relationship_____________
Name: ________________________________ Phone: _________________Relationship_____________

Medical Conditions:
Please check if you currently have or have had any of the following:

□ Asthma	□ Hepatitis B	□ Heartburn	□ Migraines
□ Hypertension	□ Seizures	□ Diabetes	□ Elevated Cholesterol
□ Depression	□ Blood Clots	□ Heart Disease	□ Urinating Difficulties
□ Psychiatric Disorder	□ Bleeding Disorder	□ Ulcers	□Thyroid Disease
	□ Hepatitis C	□ Hayfever	□ Cancer

□ other - please explain:
____
____
____

Immunizations:
Last Tetanus: ___________ Hepatitis A Series: ___________ Hepatitis B Series: ___________
Flu: ___________ Whooping Cough: ___________

Medications:
List medications and dose you are currently taking. Include vitamins and herbal supplements.
Check if no medications. □
____
____
____

Allergies:
____
____
____

Please list any past surgeries/hospitalizations and year:
____
____
____

Other:
____
____
____

Tabacco Use? □ Yes □ No packs/day ___________
Former Tobacco User? □ Yes □ No date quit ___________
Alcohol Use? □ Yes □ No drinks/week ___________

Recreational Drugs? □ Yes □ No
Type _______________
Exercise? □ Yes □ No times/week ______