

# Adventure Lake Tahoe LLC

## MEDICAL HISTORY QUESTIONNAIRE

PLEASE PRINT IN CAPITAL LETTERS

Participant Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone No: \_\_\_\_\_

PLEASE CIRCLE THE CORRECT ANSWER, ALL INFORMATION WILL BE CONFIDENTIAL

- 1). Yes / No < Are you allergic to any general medication (aspirin, sulfa, penicillin, etc.)?  
If so please indicate what medication(s) \_\_\_\_\_
- 2). Yes / No < Are you now on any prescribed medication on a permanent or semi-permanent basis? If so, please indicate the name of the medication and why it was prescribed  
\_\_\_\_\_
- 3). Yes / No < Have you ever had an epileptic seizure or been informed that you might have epilepsy?
- 4). Yes / No < Have you ever been treated for diabetes? If so, please indicate the type(s) of insulin or pills you use. \_\_\_\_\_
- 5). Yes / No < Has a medical doctor ever told you that you were anemic or had sickle cell anemia?
- 6). Yes / No < Do you have or have you ever had high blood pressure? If so, list any medication for it that you take regularly. \_\_\_\_\_
- 7). Yes / No < Do you have or have you ever had any of the following diseases? If so, please circle the appropriate ones.      Heart disease (rheumatic fever)  
Liver disease (hepatitis)    Kidney disease (infections)    Lung disease(pneumonia)
- 8). Yes / No < Have you ever been informed by a medical doctor that you have asthma? If so, what medications, if any, do you take regularly \_\_\_\_\_
- 9). Yes / No < Do you presently have an unrepaired hernia?
- 10). Yes / No < Have you ever been "knocked out" or experienced a concussion during the past 3 years? If so, give the dates of each  
\_\_\_\_\_
- 11). Yes / No < If the answer to question 10 is "yes" did the attending physician have you stay overnight in a hospital? If yes, give the dates of each \_\_\_\_\_
- 12). Yes / No < Have you ever had an injury to your neck involving nerves, vertebrae (bones), or discs that incapacitated you for a week or longer? If yes, give the dates of each such injury. \_\_\_\_\_
- 13). Yes / No < Do you wear contact lenses or corrective glasses?

PLEASE TURN THIS FORM OVER AND COMPLETE THE OTHER SIDE. THANK YOU.

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## MEDICAL HISTORY QUESTIONNAIRE

- 14). Yes / No < Have you had a fracture during the past 2 years? If yes, indicate which bone was broken and the date if happened \_\_\_\_\_
- 15). Yes / No < Have you had a shoulder dislocation, separation or other shoulder injury in the past 2 years that incapacitated you for a week or longer? If so, give the date of the injury. \_\_\_\_\_
- 16). Yes / No < Have you ever had surgery to correct a shoulder condition? If so, give the dates and what was done.
- 17). Yes / No < Have you ever had an injury to your back?
- 18). Yes / No < Do you experience Pain in your back? If yes, indicate frequency:  
Seldom / Occasionally / Frequently / With vigorous exercise / With heavy lifting
- 19). Yes / No < Have you injured your knee during the past 2 years with severe swelling as a result?
- 20). Yes / No < Have you ever been told that you injured the ligaments and / or cartilage of either knee?
- 21). Yes / No < Have you ever been advised to have surgery to correct a knee problem?
- 22). Yes / No < If the answer to No. 22 is yes, has the surgery been completed? Date
- 23). Yes / No < Have you experienced a severe sprain of either ankle during the past 2 years?
- 24). Yes / No < Have you had any injury to your foot or toes in the past 2 years. If yes, explain:
- 25). Yes / No < Do you have any chronic conditions that have not been mentioned above? If so, explain: \_\_\_\_\_

***The questions on both sides of this form have been answered completely and truthfully to the best of my knowledge.***

Participant Name (print): \_\_\_\_\_

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent / Guardian Name (print): \_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_