Volunteer Health Assessment

Name: ______________________ Date: ______________________

Address: ______________ City: __________ State: ___ Zip Code: ______

Phone Number: __________________ Date of Birth: __________________

Sex: ☐ Male ☐ Female

List the name and address of your physician or HMP Group, as well as any other physicians who are currently treating you. (Use additional sheet, if necessary.)

1. Name: ______________________________________
   Address: ______________________________________
   Phone Number: __________________ Specialty: __________________

2. Name: ______________________________________
   Address: ______________________________________
   Phone Number: __________________ Specialty: __________________

List the name, address and phone number of one person to contact in case of emergency. Please provide your relationship to this person.

1. Name: ______________________________________
   Address: ______________________________________
   Phone Number: __________________ Relationship: __________________

MEDICAL INFORMATION

Have you ever been diagnosed with the following conditions?

Heart disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No

If you answered yes, please explain. ______________________________________

____

Has a physician limited your physical activity within the past 12 months? ☐ Yes ☐ No
If yes, please explain. ____

____

MEDICAL INFORMATION

Please list the prescription and non-prescription drugs you are currently taking.

Medication	Dosage	Frequency	Medical Condition

Do you have any allergies? ☐ Yes ☐ No
Indicate substances to which you are allergic.

Substance	Reaction

All volunteers must provide proof of immunization. To do this, you must either have your doctor complete the section below or take a Rubella Titer blood test.

Measles Date of Illness ____________ Immunization Date ____________
Mumps Date of Illness ____________ Immunization Date ____________
Whooping cough Date of Illness ____________ Immunization Date ____________
Chicken Pox Date of Illness ____________ Immunization Date ____________
Rubella Date of Illness ____________ Immunization Date ____________

Rubella Titer Test Date ____________ Results ____________

All volunteers must be tested for Tuberculoses every 12 months. If you test positive, you must have a chest x-ray.
TB Test Date ____________ Results ____________
Chest X-ray Date ____________ Results ____________

Indicate if any symptoms (check all that apply):
☐ Chronic cough
☐ Night sweats
☐ Weight loss

Doctor's signature: ____________________ Date: ____________________
Please use official Doctor's stamp in this page.