South Shore Hospital

55 Fogg Rd.
South Weymouth
Massachusetts
02190-2455
Southshorehospital.org

(781) 624-4367

COMMUNITY PROGRAM HEALTH HISTORY FORM

Name: _____ DOB:_____

Street Address:_____

City/State/Zip:_____

Phone Number:_____
Home Alternate

In case of emergency, please contact:

Name:_____ Phone Number:_____
Relationship:_____ Alt. Phone Number:_____

Primary Care Physician: _____ Specialist: _____
Phone Number: _____ Phone Number: _____

Please list any allergies you have:

_____

Please check any of the following conditions that apply to you:

_____ Angina
_____ Blood Pressure
_____ Bowel/Bladder Problem
_____ Cancer (type):_____
_____ Chronic Bronchitis
_____ Congestive Heart Failure
_____ Coronary Artery Disease
_____ Diabetes
_____ Emphysema
_____ Hearing Problem
_____ Heart Attack
_____ Pacemaker/Defibrillator
_____ Seizures
_____ Vision Problem

Please list current medications, surgeries, and any other medical conditions that apply to you:

_____
_____
_____
_____

We ask that you alert your instructor to any changes in your medications or medical history.

_____ _____
Participant Signature Date