



Orange County Chapter  
**The Achievers**  
"If I can do this, I can do anything!"

# Participant Medical History

Today's Date: \_\_\_\_\_

**Participant's Name:** \_\_\_\_\_  
Last First

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Zip \_\_\_\_\_  
Street City

Phone: \_\_\_\_\_ Phone and contact  
for emergencies: \_\_\_\_\_

**Present Condition:** \_\_\_\_\_  
\_\_\_\_\_

**Medical Problems:** \_\_\_\_\_  
\_\_\_\_\_

**Medications:** \_\_\_\_\_

## Other Medical Problems

Vision	
Hearing	
Breathing	
Swallowing	
Digestion	
Heart	
Bones	
Nerves	
Skin	
Infection	
Seizures	
Diabetes	
Allergies	

**Physician's Name:** \_\_\_\_\_

Address: \_\_\_\_\_  
Street City Zip