

Wyoming Cowboy Challenge Academy Medical Information

Candidate Name: _____ Date of Birth: _____

Male Female Social Security #: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Guardian/Emergency Contact: _____

Relationship to Candidate: _____

Home Phone Number: _____ Okay to leave a message? Y N

Cell Phone Number: _____ Okay to leave a message? Y N

Work Phone Number: _____

Email Address: _____

Guardian/Emergency Contact: _____

Relationship to Candidate: _____

Home Phone Number: _____ Okay to leave a message? Y N

Cell Phone Number: _____ Okay to leave a message? Y N

Work Phone Number: _____

Email Address: _____

With Whom may we Discuss Your Health Issues:	
Name:	Relationship:

Allergies/Intolerances/Sensitivities: _____

Allergic to Latex: Y N

Past Surgeries with Dates: None

Anesthesia Complications: Y N

Have you ever been patient in any type of hospitals?

If yes, specify when, where, and give details

Social/Psychosocial History:

- Tobacco Use: Y N Quit
- Alcohol: Y N Quit
- Alcohol Abuse: Y N
- Street Drugs: Y N Quit

Have you ever been treated for mental conditions?

If yes, specify: when, where, and give details

Family History: (mother, father, brother, sister)

- Heart Disease: Y N Who: _____
- Stroke: Y N Who: _____
- Cancer: Y N Who: _____
- Diabetes: Y N Who: _____

Current Medications: (include all prescription medications, non-prescription/Over-the-Counter medications, herbs and vitamins, with dose and directions)

Past History / Diseases:

Special Diet: Y N Type: _____

Have you ever had, or do you have you now:

(For every item checked 'YES', must be explained below, including date of occurrence.)

<u>Check each item</u>	<u>Y</u>	<u>N</u>	<u>?</u>	<u>Explanation, with date</u>
Do wear glasses or contact lenses?				
Have vision in both eyes?				
Wear a hearing aid?				
Frequent or severe headache				
Eye trouble				
Ear, nose, or throat trouble				
Hearing loss				
Sinusitis				
Hay Fever				
Head injury				
Head injury with period of unconsciousness				
Skin diseases				
Thyroid disease				
Tuberculosis				
Asthma				
Heart trouble				
Broken bones				
Rupture/Hernia				
Bed wetting since age 12				
Diabetes				
Bone, joint or other deformity				
Lameness				
Recurrent back pain				
STD – Syphilis, gonorrhoea, genital warts, etc.				
“Trick” or locked knee				
Foot trouble				
Epilepsy, seizures/fits (childhood seizures)				
Car, train, sea, or air sickness				
Frequent trouble sleeping				
Depression or excessive worry				
Loss of memory or amnesia				
Nervous trouble/anxiety				
Periods of unconsciousness				
Anorexia or Bulimia				

<u>Check each item</u>	<u>Y</u>	<u>N</u>	<u>?</u>	<u>Explanation, with date</u>
Arthritis, Rheumatism or Bursitis				
Had Chicken Pox				
Lived with anyone who had tuberculosis				
Coughed up Blood				
Attempted suicide				
Been a sleepwalker				
Stutter or stammer?				
Wear a brace or back support?				
Scarlet fever, erysipelas				
Swollen or painful joints				
1. Have you been refused employment or been unable to hold a job or stay in school due to: •Sensitivity to chemicals, dust, sunlight, etc. •Inability to perform certain motions? •Inability to assume certain positions? •Other medical reasons?				
Have you ever had any illness or injury other than those already noted? If yes, specify when, where, and give details				
<u>Females Only:</u> Have you ever:				
•Had a change in menstrual pattern				
•Been pregnant				
•Been treated for female disorder				
•Are currently pregnant				