COPE HEALTH HISTORY

Name:					
First		Middle	Last		
Telephone:					
Home		Work		Cell	
Personal physician:				Telephone:	
Name					
In case of emergency please contact:				Telephone:	
Name					
Special dietary considerations:					
List known allergies:					
If you are allergic to insect stings, do you have an insect sting kit (e.g. EpiPen)?				Yes	No
List required medications:					
Do you wear contact lenses?			Are you pregnant?		
Have you had, or do you now have (circle if yes):			Heart Attack	Diabetes	Asthma	Angina
Whiplash	Chest Pains	Drug Reactions	High Blood Pressure		Heart Murmur
If you answered "yes" to any of the above, explain and include date:					
Do you have any other medical conditions that we should be aware of:					