AGNESIAN HEALTHCARE

VOLUNTEER MEDICAL HISTORY

VOLUNTEER SERVICES

Name: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Date of birth: _____

Family physician: _____ Physician phone: _____

In case of emergency, notify: _____ Phone: _____

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS:

Y	N		Y	N	
❑	❑	arthritis	❑	❑	high blood pressure
❑	❑	asthma	❑	❑	hernia
❑	❑	back problems	❑	❑	kidney problems
❑	❑	chicken pox	❑	❑	hepatitis
❑	❑	depression	❑	❑	mental illness
❑	❑	diabetes	❑	❑	tuberculosis
❑	❑	epilepsy	❑	❑	rheumatic fever
❑	❑	venereal disease	❑	❑	joint problems
❑	❑	fainting	❑	❑	German measles
❑	❑	heart problems	❑	❑	Red measles
❑	❑	mumps			

HEALTH HISTORY: (check yes or no)

Have you had any illness other than any of the above?

❑ no ❑ yes

If yes, please state the nature of the illness and when you had it:

_____

_____

Do you have any allergies? ❑ no ❑ yes

If yes, please specify: _____

_____

Are you currently taking any medicine? ❑ no ❑ yes

If yes, list name of medication and the physician who prescribed it. _____

_____

_____

_____

_____

Please check all **IMMUNIZATIONS** that you have had and bring proof of immunizations with you.

❑ polio ❑ pertussis ❑ mumps

❑ diptheria ❑ measles ❑ rubella

❑ Tetanus - Date: _____

❑ Hepatitis B - 3 Dates: _____

_____

_____

❑ Hepatitis Surface Antibody Titer

❑ Influenza vaccine - Date:

Do you have any condition that would restrict you or require a special volunteer assignment? ❑ no ❑ yes

If yes, please explain: _____

_____

_____

_____

_____

I CERTIFY MY ANSWERS TO THE ABOVE TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____

Signature of applicant (or guardian if minor)

_____

Relationship to applicant

_____

Date

❑ St. Agnes Hospital ❑ St. Francis Home

❑ Hospice - Fond du Lac ❑ Hospice - Green Lake

❑ Ripon Medical Center ❑ Waupun Memorial Hospital

Please return completed form to Associate Health.