Medical Alert: ______________________________
Special Considerations: ______________________

CDA Program

HEALTH HISTORY

PERSONAL/MEDICAL INFORMATION

NAME: ____________________ PHONE (RES) ____________ (BUS) ____________
ADDRESS: ______________________________ POSTAL CODE: ____________
DATE OF BIRTH: __________ AGE: ____ SEX: ______ GENDER: ______ PRONOUN PREFERENCE: __________
OCCUPATION/STUDENT STATUS __________ PHYSICIAN: __________ ADDRESS: ______________
PHONE: ____________ Date of last medical examination: ____________ Reason: ______________
Have you ever been hospitalized? ________ If yes, state why and date of each: ______________
Any related complications? ______________________________
In case of emergency notify: ______________________________
Relation to client: ____________________ PHONE: (Residence) ____________ (Cell) ________

DO YOU OR HAVE YOU EVER HAD: (Please circle No or Yes)

1. Heart valve replacement
2. Heart attack
3. Previous Endocarditis
4. Treatment for heart disease/heart attack
5. Pain in chest following physical activity
6.

Health History Update (follow up appointments)

Medical Alert: ____