

FERAL HUMAN EXPEDITIONS  
CONFIDENTIAL MEDICAL HISTORY

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Do you have allergic reactions to any food, drugs, insects, plants, or other substances?  
Please explain:

\_\_\_\_\_  
\_\_\_\_\_

If yes, do you carry an Epi-Pen, auto injector, medications, or devices? \_\_\_\_\_

Are you presently under the care of a physician? If yes, please explain medical condition/s.

\_\_\_\_\_  
\_\_\_\_\_

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

Physician's Phone: \_\_\_\_\_

Are you presently taking any prescription medications? If yes, what type and for what?

\_\_\_\_\_  
\_\_\_\_\_

If no allergies or medical conditions exist, initial here: \_\_\_\_\_

In Case of Emergency, Notify: \_\_\_\_\_

Contact's Phone: \_\_\_\_\_

Contact's relationship to you: \_\_\_\_\_