

# Medical History

Due to the environment and physical nature of AMS courses and expeditions, participants should be healthy and physically fit. The information on this form is held confidentially and provides AMS with helpful information to best serve you and ensure a successful experience. Please be sure to notify us of any changes that may occur before the start of your program!

Name: \_\_\_\_\_ Course/Expedition Dates: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: \_\_\_\_\_

Yes No **Please explain in detail any questions answered 'yes' below. Please use the back side or additional paper if necessary.**

Do you currently have any medical condition that requires medication and or the care of a doctor? If yes, please explain.

List any medications you are currently taking. Please explain why.

Do you have any allergies to food or medication or to anything that you are aware of? If yes, what is the nature of the reaction?

Have you been hospitalized in the past 5 years? If yes, please explain.

Have you ever been told by a doctor that you had epilepsy, diabetes, high blood pressure, a heart condition, asthma or respiratory condition, ulcers, colitis or intestinal problems, or any disease? If yes, please explain.

Do you have any history of joint injuries or pain? If yes, please provide a history and status on your current condition.

Have you ever had acute mountain sickness, pulmonary, or cerebral edema? If yes, please explain and at what elevation.

Have you ever suffered from depression or mental illnesses?

Do you have any health problems or restrictions that could in any way effect your well being on this course or expedition?

Have you ever experienced frostbite? If yes, please explain the severity and your current condition?

Are you a vegetarian?

## HEALTH INSURANCE

We recommend that all students be covered by health and accident insurance. It is your responsibility to make sure your insurance will cover you for the duration of the course or expedition. Individuals who do not already belong to a regular health program should investigate short-term policies from local insurance agents.

Yes No

Do you have personal health/accident insurance?

Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Agreement # \_\_\_\_\_

I have answered all questions to the best of my knowledge.

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Legal Guardian if under 18: \_\_\_\_\_ Date: \_\_\_\_\_