

UNIVERSITY OF UTAH
Neuropsychiatric Institute ROPES Program
MEDICAL DISCLOSURE/ HEALTH FORM

We require that this form be filled out in full

Name: _____ Age: _____

Address: _____

Phone number: _____

In case of an emergency, please notify:

Name: _____

Phone number: _____ Relationship: _____

Physician name: _____ Physician phone: _____

Medical Policy and number: _____

1. Do you smoke? Number of packs per day _____ YES NO
2. Do you wear glasses or contacts? YES NO
3. Are you currently under a physicians care? YES NO
If yes, please explain: _____
4. Are you allergic to bee stings? YES NO
If yes, do you carry a bee sting kit? YES NO
5. Do you have any allergies? YES NO
If yes, please explain: _____
6. Have you had a recent injury, illness, or operation? YES NO
If yes, please explain: _____
7. Do you have diabetes, seizures, frequent fainting/ dizziness? YES NO
If yes, please explain: _____
Are you on medication for any of the above? YES NO
8. Do you have any neck, back, or shoulder pain or injury? YES NO
If yes, please explain: _____
9. Does your weight present health problems or limit physical activities? YES NO
Please explain: _____
10. Do you have a history of heart problems or high blood pressure? YES NO
Please explain: _____
Are you taking medication for heart and or blood pressure? YES NO
11. Are you currently taking medication not mentioned above? YES NO
If yes, please explain: _____
12. Do you require special assistance of any type? YES NO
If yes, please explain: _____

Doctors' orders are required to participate in activities for participants who answered yes to 3, 6, 8, and 10.

Participant's Signature: _____ Date: _____

