



Weekend Intervention Program

Health and Medical Data:

Mail all forms to:

**Weekend Intervention Program
Center for Interventions, Treatment and Addictions Research
Wright State University Boonshoft School of Medicine
216 Medical Sciences Building
3640 Colonel Glenn Highway
Dayton, Ohio 45435**

Name: _____

Social Security Number: _____ Age: ____ Male: _____ Female: _____

THE FOLLOWING INFORMATION WILL HELP ASSURE YOUR HEALTH AND SAFETY.
IN THE CASE OF A MEDICAL EMERGENCY THE HOSPITAL AND/OR ATTENDING PHYSICIAN
MUST HAVE THIS INFORMATION.

1. In the past two years, have you been in a hospital for medical treatment or a surgical operation?

Yes _____ No _____ If yes, please tell what for and when:

2. Please explain any serious illnesses you may have had in the last six months.

3. Have you had any serious accidents in the last year, for example, something that kept you from feeling well for more than just a day or two?

4. Are you allergic to any drugs or medicine? Have you ever had an unpleasant reaction to any medicine or drug? Please explain.

5. Do you have any special needs or is there anything about your health or well being that we should know? (i.e. mobility limitations, reading difficulties, etc.)

6. **Females Only:** Are you currently pregnant? No_____ Yes_____ If yes, how many months? _____

7. Who is your family or personal physician?

Name: _____

Address: _____

Telephone: _____