

# MEDICAL RECORD HISTORY

(Fill out and turn into your Youth Pastor or Leader.)

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone #(\_\_\_\_\_) \_\_\_\_\_ Work #(\_\_\_\_\_) \_\_\_\_\_

Sex: F \_\_\_\_\_ M \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Blood Type \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Medical insurance policy name \_\_\_\_\_

Policy # \_\_\_\_\_

Does the policy cover accidental death and dismemberment? yes \_\_\_\_\_ no \_\_\_\_\_

## In case of an emergency contact:

1. Name \_\_\_\_\_ Day Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

2. Name \_\_\_\_\_ Day Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Childhood immunizations: (These must be up-to-date for international travel)

Yes	No	Type	Year
_____	_____	Mumps/Measles/Rubella	_____
_____	_____	Diphtheria/Pertussis/Tetanus	_____
_____	_____	Polio	_____
_____	_____	Tetanus*	_____
_____	_____	Other	_____
_____	_____	Other	_____

\*A current Tetanus shot is required.

**Yes No Have you ever been treated for:**

\_\_\_\_\_ \_\_\_\_\_ Asthma or chronic wheezing

\_\_\_\_\_ \_\_\_\_\_ Emphysema or other lung and/or respiratory problems

\_\_\_\_\_ \_\_\_\_\_ Chronic persistent cough or shortness of breath

\_\_\_\_\_ \_\_\_\_\_ Hay fever or allergies

\_\_\_\_\_ \_\_\_\_\_ Tuberculosis

\_\_\_\_\_ \_\_\_\_\_ Any skin disorder or disease other than acne

\_\_\_\_\_ \_\_\_\_\_ Chronic / recurrent ear or eye problems

\_\_\_\_\_ \_\_\_\_\_ Impairment of hearing or vision, Meniere's Disease, cataracts,  
or glaucoma

\_\_\_\_\_ \_\_\_\_\_ Persistent, recurring indigestion, stomach, or duodenal ulcers

\_\_\_\_\_ \_\_\_\_\_ Diabetes or hypoglycemia (*low blood sugar*) \* Diabetics should note that a few of the conditions that we

will be experiencing on the mission field include times when there will be limited access to supplies, irregular eating, and an unpredictable diet. Necessary precautions can be taken to compensate for these few times.

**Yes No**

- Gall bladder stones or colic
- Jaundice, cirrhosis, or other liver problems
- Intestinal or bowel problems, colitis, diverticulitis, hemorrhoids, other rectal problems or bleeding
- Any test results indicating exposure to the AIDS virus
- Albumin, blood or pus in the urine, painful or frequent urination, or kidney problems
- Serious bodily injury
- Mental health counseling or psychiatric treatment
- Rheumatism, gout, arthritis, or other forms of swollen painful joints
- Chronic back pain, back injury or surgery; sciatica, bone or joint disorders
- Cysts, tumors or growths of any kind, hernia or rupture
- Cancer
- Fainting spells, dizziness, convulsions, epilepsy or seizure disorder
- High blood pressure, heart murmurs, or other cardiac problems
- Vein or circulatory trouble
- Migraine headaches
- Goiter, thyroid ailment, high or low metabolism
- Anemia or other blood disorder
- Abnormality of reproductive systems, prostrate problems, breast disorder, menstrual disorder, or venereal disease
- Parkinson disease
- Severe knee injury problems
- Severe allergic reactions to either food, medicines, bee stings or any other insect bite or sting
- Any other diseases, deformity or disability not listed above

**IF YOU CHECKED "YES" TO ANY OF THESE YOU ARE REQUIRED TO HAVE YOUR DOCTOR:  
1. SEE AND SIGN THIS COMPLETED FORM and 2. COMPLETELY FILL OUT THE DOCTOR'S  
RELEASE.**

*Please complete the following questions:*

Are you currently taking any prescribed medication? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, specify medication and dose. \_\_\_\_\_

Are you currently using any non-prescription drugs on a regular basis; such as antihistamines, aspirin, vitamins, or sleeping aids? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, specify the type of item. \_\_\_\_\_

Have you ever received treatment/counseling for drinking/chemical abuse? Yes \_\_\_ No \_\_\_

If yes, specify when and where. \_\_\_\_\_

Are you currently under a physician's care for any illness?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain. \_\_\_\_\_

Have you ever had limitations or restrictions placed on you pertaining to gymnasium / sports activities at school for a period greater than two months?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain. \_\_\_\_\_

**Family Medical History:**

Do your grandparents, parents or siblings have:

<b>Yes</b>	<b>No</b>		<b>If yes, who</b>
_____	_____	Diabetes	_____
_____	_____	Hypertension	_____
_____	_____	Heart disease	_____
_____	_____	Depression	_____
_____	_____	Mental illness	_____

Date and attending physician of your last physical exam:

\_\_\_\_\_

List all surgical operations or hospitalization you have undergone.

1. Operation / illness /reason:

\_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name and address of hospital:

\_\_\_\_\_

Name of physician \_\_\_\_\_

Remaining effects \_\_\_\_\_

2. Operation / illness /reason:

\_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name and address of hospital:

\_\_\_\_\_

Name of physician \_\_\_\_\_

Remaining effects \_\_\_\_\_

If you have been hospitalized more than twice, explain:

\_\_\_\_\_

Please provide any details pertaining to your health not covered by the above questions:

\_\_\_\_\_

\_\_\_\_\_

**Applicant's signature** \_\_\_\_\_

**Parent's signature** \_\_\_\_\_

**Physician's signature (if applicable)** \_\_\_\_\_