Medical Information Form

Name ______________________________ Date ____/____/____

Address ____

City ________________ State ______________ Zip ____________

Phone ________________ Age ______________ Gender (M/F) __________

Birth Date ____/____/____ Marital Status ______________________

History of Past Illness: Have you had

☐ Asthma	☐ High Blood Pressure	☐ Cancer (Site ____________)
☐ Diabetes	☐ Ulcer or Gastritis	☐ Thyroid Problem
☐ Hypoglycemia	☐ Kidney Problem	☐ Liver Problem
☐ Blood Problem	☐ HIV/AIDS	☐ Arthritis
☐ Heart Attack	☐ Abnormal Heart Rhythm	☐ Heart Trouble/Failure
☐ Lung Disorder	☐ Nervous Disorder	☐ Hepatitis
☐ Epilepsy	☐ Migraines	☐ Seasonal Allergies
☐ Tuberculosis	☐ Hearing Impairment	☐ Vision Impairment
☐ Circulatory Trouble	☐ Mental Problem	☐ Intestinal/Bowel Problem

☐ Any other disease or disability not listed above

If you checked any of the boxes, please explain each:

____

____

Most Recent Immunizations: (Dates)

Tetanus ______________ Flu Vaccine ______________ Other ______________

Operations:

Have you ever had any surgery? (circle) Yes No

If yes, please list

____

____

What is your blood type? ___________

Have you been treated by a physician or been disabled or hospitalized during the last 2 years?
If Yes, please describe: ____

____

Have you ever been treated for (or are now suffering from) emotional difficulties?

____

Do you have any other limitations or significant health conditions which might affect your involvement with our mission trip or which you believe your physician would want us to know about?

____

____

Do you have any problems walking long distances? ______________________

Do you have any problems climbing stairs? ______________________

Do you have any limitations to strenuous physical work? ______________________

Do you have chest, back, or joint pain? ______________________

Are you claustrophobic? ______________________

Date of last physical: ______________________

Are you pregnant? ______________ Due Date: ______/______/______

Do you have any known allergies, including food/drugs/medications? Please explain:

____

Do you have any dietary restrictions? ______________________

Please list any medications you are currently taking, prescription and over-the-counter:

____

____

Have you ever been on a mission trip before? (circle) Yes No
If yes, where and for how long?

____

____

Physician's Name: ____

Physician's Phone Number: ____

Participant's Signature: ______________________ Date: ___________