Medical Assessment

Please complete each question. If you need more space for explanations, attach a separate piece of paper.

Name of Applicant _____

Social Security Number _____

In case of medical emergency, who should be contacted?

Name _____ Phone # (work)_____ (home) _____

Address _____

Name _____ Phone # (work)_____ (home) _____

Address _____

How do you appraise your present health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Childhood Immunizations (These must be up-to-date)

Type:	**Year immunization given:**
Mumps / Measles / Rubella	_____
Diphtheria / Pertussis / Tetanus	_____
Polio	_____
Tetanus	_____
Other:_____	_____

Have you ever been treated for any of the following:

(every item must be checked, please explain a "yes" answer on the back of this form)

Yes No

☐ ☐ Asthma or chronic wheezing
☐ ☐ Emphysema or other lung and/or respiratory problems
☐ ☐ Chronic persistent cough or shortness of breath
☐ ☐ Tuberculosis
☐ ☐ Any skin disorder or disease other than acne
☐ ☐ Recurring ear or eye problems, impairment of hearing or vision, meniere's disease, cataracts or glaucoma
☐ ☐ Persistent, recurring indigestion, stomach or duodenal ulcers
☐ ☐ 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; kidney problems
☐ ☐ Diabetes or hypoglycemia (low blood sugar)
☐ ☐ Emotional or Mental health counseling or psychiatric treatment
☐ ☐ Rheumatism, gout, arthritis or other forms of swollen or painful joints
☐ ☐ Chronic back pain, back injury or surgery; sciatica, scoliosis or other bone or joint disorder

Yes No

☐ ☐ 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
☐ ☐ Significant migraine headaches
☐ ☐ Goiter, thyroid ailment, high or low metabolism
☐ ☐ Anemia or other blood disorder
☐ ☐ Abnormality of reproductive systems, prostate problems, breast disorder, menstrual disorders or venereal disease
☐ ☐ Parkinson's Disease
☐ ☐ Significant knee injury or problems
☐ ☐ Significant allergic reactions to either food, medicines, bee stings or any other insect bite or sting
☐ ☐ Any other diseases not listed above
☐ ☐ Any other serious bodily injuries, physical limitations or disabilities not listed above.

Please describe: _____

_____

If you checked "yes" to any of the previous questions, your doctor must complete the doctor's release on the bottom of this page.

Are you currently taking any prescribed medication? (If yes, please specify the medication and dosage.) ☐ Yes ☐ No

_____

Are you currently using any non-prescription drugs on a regular basis? (If yes, please specify the medication and dosage.)
☐ Yes ☐ No _____

Have you ever received treatment or counseling for alcohol or chemical abuse? (If yes, please specify when and where.)
☐ Yes ☐ No _____

Are you presently under a physician's care? (If yes, please explain.) ☐ Yes ☐ No

_____

Do you have a condition that requires a special diet? (If yes, please explain.) ☐ Yes ☐ No

_____

Do you have any chronic or recurring health problems? (If yes, please explain) ☐ Yes ☐ No

_____

Do your grandparents, parents or siblings have any of the following: (If you answer "yes" to any of these, please explain who the person is and what the severity of the problem is.)

☐ Yes ☐ No Diabetes _____
☐ Yes ☐ No Hypertension _____
☐ Yes ☐ No Heart Disease _____
☐ Yes ☐ No Depression _____
☐ Yes ☐ No Mental Illness _____

What was the date and location of your last physical exam? _____
Who was the attending physician? _____
List all operations or hospitalizations you have undergone:
1. Date _____ Operation and reason _____
Attending physician _____ Name and location of hospital _____
Remaining effects _____
2. Date _____ Operation and reason _____
Attending physician _____ Name and location of hospital _____
Remaining effects _____

Please provide any details pertaining to your health not covered by the above questions. (If more space is needed, attach a separate sheet of paper.) _____

In case of medical emergency, what doctor (knowledgeable about your health) should be contacted?
Doctor's Name _____ Phone # _____
Address _____

I certify that the information listed on this form is correct to the best of my knowledge. In case of emergency, I hereby authorize any necessary medical treatment by medical personnel.

Signature of Applicant _____ Date _____

PHYSICIAN'S RELEASE (This should be completed if any of the questions on page one were marked "yes".)
I have reviewed this applicant's medical information and history and this completed form and I have performed a physical exam on the applicant. I find him/her to be in a suitable condition for international travel, participation in high-intensity activities (such as hiking several miles) and conditions in a third-world country.

Physician's Signature _____ Date _____
Print Name _____ Phone # _____
Address _____