Adventures In Missions

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Report of Medical History

To the applicant: Please complete pages 1 and 2 *before* going to your physician for a physical examination. Then take all four pages with you to your physical. Your physician will complete page 3. Page 4 provides extra space for more details, if needed.

Note: This information is strictly for the use of the AIM program and will not be released to anyone without your knowledge and consent.

Applicant Information

Name

Last Name _______ First Name _______ Middle _______ Applicant Phone Number _______

Address

Street _______ City _______ State/Province _______ ZIP/Postal Code _______

Other Details

Citizenship _______ Date of Birth _______ ☐ Male ☐ Female

Family History

Relationship	Age	State of Health	Occupation
Father			
Mother			
Brothers			
Sisters			

Have any of your relatives ever had any of the following?

Type of Illness	Yes	No	Relationship	Additional Comments
Heart Disease				
Asthma, Hay Fever				
Epilepsy, Convulsions				
Cancer, Tumor, Cyst				

Personal History

Have you ever had the following? Please check "Yes" or "No" for each condition.

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Sinusitis	☐	☐	Pain/Pressure in chest	☐	☐	Disease or injury of joints	☐	☐
Eye trouble	☐	☐	Heart palpitations	☐	☐	Knee problems	☐	☐
Asthma, Hay fever	☐	☐	Heart murmur	☐	☐	Back problems	☐	☐
Recurrent Headaches	☐	☐	High or low blood pressure	☐	☐	Weakness, paralysis	☐	☐
Chronic cough	☐	☐	Stomach or intestinal trouble	☐	☐	Shortness of breath	☐	☐

Please explain about any of the above conditions for which you checked "Yes." Use additional space on page 4 if necessary.

____

____

____

PERSONAL HISTORY (CONT.)

Have you ever: If yes, please explain in detail (use additional space on page 4 if necessary):

Have you ever:	Yes	No	If yes, please explain in detail
Had seizures	☐ Yes	☐ No	
Had fainting spells	☐ Yes	☐ No	
Had an eating disorder	☐ Yes	☐ No	
Had breathing problems	☐ Yes	☐ No	
Had psychiatric counseling	☐ Yes	☐ No	
Had chronic illness	☐ Yes	☐ No	
Had cancer or a tumor	☐ Yes	☐ No	
Had insomnia	☐ Yes	☐ No	
Frequent anxiety/nervousness	☐ Yes	☐ No	
Frequent depression	☐ Yes	☐ No	

Within *the last two years* have you ever: If yes, please explain in detail (use additional space on page 4 if necessary):

Within the last two years have you ever:	Yes	No	If yes, please explain in detail
Had psychiatric counseling	☐ Yes	☐ No	
Been sexually active	☐ Yes	☐ No	
Taken medication for an emotional disorder	☐ Yes	☐ No	
Taken medication for depression	☐ Yes	☐ No	
Had a significant gain or loss of weight	☐ Yes	☐ No	
Struggled with ADD or ADHD	☐ Yes	☐ No	
Struggled with violence or anger	☐ Yes	☐ No	
Struggled with inability to make friends	☐ Yes	☐ No	
Struggled with thoughts of suicide	☐ Yes	☐ No	

Are you a vegetarian? ☐ Yes ☐ No If yes, for how long? ____________________

Please note that you may need to eat meat as a part of cultural sensitivity.

Are you currently taking any prescription medication? ☐ Yes ☐ No If yes, give details (name, dosage, reason for use):

____

____

____

Do you use any non-prescription drugs on a regular basis? ☐ Yes ☐ No If yes, give details:

____

____

____

Do you have *any* physical impairment? ☐ Yes ☐ No If yes, give details:

____

____

____

Applicant's Signature: ____________________ **Date:** ____________________

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Report of Health Evaluation

To the examining physician: Please review the applicant's history on pages 1 and 2, then complete the information below.

Basic Health Information

Blood Pressure: _______ / _______ **Height:** _______________ **Weight:** _______________

Corrected Vision: Right 20 / _______ Left 20 / _______

Immunization (Required by Texas law)

Diphtheria - Tetanus (TD adult type - within 10 years) ☐ Yes ☐ No Date of injection (required): ____________________

Health Details

Does the applicant have abnormalities of: If yes, please describe fully (use additional space on page 4 if necessary):

Head, ears, nose, or throat	☐ Yes	☐ No	____________________
Respiratory	☐ Yes	☐ No	____________________
Cardiovascular	☐ Yes	☐ No	____________________
Gastrointestinal	☐ Yes	☐ No	____________________
Eyes	☐ Yes	☐ No	____________________
Musculoskeletal	☐ Yes	☐ No	____________________
Metabolic / Endocrine	☐ Yes	☐ No	____________________
Neuropsychiatric	☐ Yes	☐ No	____________________
Skin	☐ Yes	☐ No	____________________

Further questions (please comment on all "Yes" answers; use additional space on page 4 if necessary):

Is there loss or seriously impaired function of any paired organ?

☐ Yes ☐ No If yes, please explain: ____________________

Does the applicant have any form of epilepsy?

☐ Yes ☐ No If yes, please explain: ____________________

Is the applicant a diabetic?

☐ Yes ☐ No If yes, please explain: ____________________

Do you have any recommendations regarding the care of this applicant?

☐ Yes ☐ No If yes, please explain: ____________________

Is the applicant now under treatment for any medical or emotional condition?

☐ Yes ☐ No If yes, please explain: ____________________

Overall Assessment

How would you rate the applicant's overall physical condition? Poor Health 1 2 3 4 5 Great Health

Physician

Physician's name (please print): ____________________ Physician's signature: ____________________

Physician's mailing address: ____________________
Street City State/Province ZIP/Postal Code

Date: ____________________

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This space is provided for additional comments and explanations for items on pages 1-3.