Report of Medical History

To the Applicant: Please complete pages 1 - 4 before going to your physician for a physical examination. Then take all 7 pages with you to your physical. Your physician will complete pages 5 - 7. Page 7 provides extra space for more details, if needed.

Once the form is signed by your physician, please take a photo of the forms, scan, and email the PDF to aim@sibi.cc

Please bring the original signed form with you to AIM Registration.

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

Name _____
Last Name First Name Middle

Address _____ _____
Street Apt. # (if needed)

_____ _____ _____
City State Zip Code

Phone _____ Date of Birth _____

Gender Male Female Citizenship _____

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	Y	N	Relationship	Additional Comments
Heart Disease				
Asthma, Hay Fever				
Epilepsy, Convulsions				
Cancer, Tumor, Cyst				

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

	Y	N		Y	N		Y	N
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”…

Report of Medical History (continued)

Have you ever:			**If yes, please explain in detail:**
Had seizures	Y	N	
Had fainting spells	Y	N	
Had an eating disorder	Y	N	
Had breathing problems	Y	N	
Had psychiatric counseling	Y	N	
Had chronic illness	Y	N	
Had cancer or a tumor	Y	N	
Had insomnia	Y	N	
Frequent anxiety/nervousness	Y	N	
Frequent depression	Y	N	
Within the last 2 yrs have you:			**If yes, please explain in detail:**
Had psychiatric counseling	Y	N	
Been sexually active	Y	N	
Taken medication for an emotional disorder	Y	N	
Taken medication for depression	Y	N	
Had a significant gain or loss of weight	Y	N	
Had ADD or ADHD	Y	N	
Struggled with violence or anger	Y	N	
Had difficulty making new friends	Y	N	
Had any thoughts of suicide	Y	N	
Intentionally inflicted pain or injury on yourself (cutting, etc.)	Y	N	

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

If yes, please give the reasoning behind your decision:

(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, please give details (name, dosage, reason for use):

Do you use any non-prescription drugs on a regular basis? Yes No

If yes, please give details:

Do you have a physical impairment? Yes No

If yes, please give details:

I understand I am applying to be a missionary apprentice and will likely encounter difficult living conditions and stressful situations. I have answered this form completely truthful.

Applicant's Signature: _____ Date: _____

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

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	Y	N	
Respiratory	Y	N	
Cardiovascular	Y	N	
Gastrointestinal	Y	N	
Eyes	Y	N	
Musculoskeletal	Y	N	
Metabolic / Endocrine	Y	N	
Neuropsychiatric	Y	N	
Skin	Y	N	

Further Questions (please comment on all “Yes” answers; use additional space on page 4 if needed):

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 under treatment for any medical or emotional condition? Yes No
If yes, please explain:

How would you rate the applicant’s overall physical condition? Poor Great

Physician

Physician's Name (please print): _____

Physician's Signature: _____ Date: _____

Physician's Mailing Address:

_____

Street

_____

City State Zip Code

This space is provided for additional comments for items on previous pages:

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