Adventures In Missions

3723 34th St. • Lubbock, TX 79410 • aim.sunset.bible • 806-788-3244 • Submit form to aim@sunset.bible

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. Scan all pages and email to aim@sunset.bible.

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.

	Yes	No		Yes	No		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):

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: If yes, please explain and include dates (if needed, use additional space on page 4):

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	
Had ADD or ADHD	☐ Yes	☐ No	
Struggled with violence or anger	☐ Yes	☐ No	
Had difficulty making new friends	☐ Yes	☐ No	
Had any thoughts of suicide	☐ Yes	☐ No	
Intentionally inflicted pain or injury on yourself (cutting, etc.)	☐ Yes	☐ No	

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, 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:

☐ Yes, 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:** _____

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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				Great Health
1	2	3	4	5

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.