Youth With A Mission, Constanta

"To know God and make Him known."

HEALTH FORM

Name_____

In case of emergency, contact _____ Phone _____

PERSONAL HISTORY: Please answer all questions. Explain any "Yes" answer in the space below.

HAVE YOU EVER HAD, OR DO YOU HAVE, ANY OF THE FOLLOWING?

	Yes	No		Yes	No		Yes	No
Skin conditions	__	__	Shortness of breath	__	__	Stomach/Duodenal Ulcer	__	__
Eye trouble	__	__	Hay Fever, Asthma	__	__	Gall bladder problems	__	__
Ear trouble	__	__	Heart trouble	__	__	Jaundice	__	__
Head injury	__	__	High blood pressure	__	__	Hepatitis	__	__
Recurrent headache	__	__	Low blood pressure	__	__	Intestinal troubles	__	__
Epilepsy	__	__	Rheumatism/Arthritis	__	__	Recurrent diarrhea	__	__
Fainting spells	__	__	Back problems	__	__	Diabetes	__	__
Mental/Nervous dis.	__	__	Dislocation of joints	__	__	Kidney Disease	__	__
Weakness	__	__	Broken bones	__	__	Anemia	__	__
Paralysis	__	__	Eating disorders	__	__	Venereal Disease	__	__
Insomnia	__	__	Anorexia Nervosa	__	__	Tumor/Cancer	__	__
Allergy	__	__	Bulimia	__	__			
Penicillin	__	__	Surgery	__	__			
Sulfonamides	__	__	Appendectomy	__	__			
Serum	__	__	Hernia repair	__	__			
Other (specify)	__	__	Tonsillectomy	__	__			
Food (specify)	__	__	Others (specify)	__	__			

Other (please explain) _____

_____

Are you now under doctor's care for any condition? ☐ No ☐ Yes (specify) _____

Are you taking any medication at this time? ☐ No ☐ Yes (specify) _____

Any physical handicaps or conditions which require special attention? ☐ No ☐ Yes (specify)

_____

Do you have a history of emotional instability or psychiatric treatment? ☐ No ☐ Yes (specify)

_____

Are you ☐ overweight? ☐ underweight? Pounds over/under _____ Blood type _____

Would you rate your health conditions as ☐ Excellent ☐ Good ☐ Fair ☐ Poor

FAMILY HISTORY: Have any of your relatives ever had any of the following?

Yes	No		Relationship	Yes	No		Relationship
__	__	Tuberculosis	_____	__	__	Arthritis	_____
__	__	Diabetes	_____	__	__	Stomach Disease	_____
__	__	Kidney Disease	_____	__	__	Asthma, Hay Fever	_____
__	__	Heart Disease	_____	__	__	Convulsions,Epilesy	_____
__	__	Hypertension	_____	__	__	Cancer	_____

Have you ever had any of the following COMMUNICABLE DISEASES?

Yes	No		Yes	No		Yes	No	
__	__	Chicken pox	__	__	Pertussis	__	__	Mumps
__	__	Measles (Rubella)	__	__	Scarlet Fever	__	__	Other (specify)
__	__	Measles (Rubeola)	__	__	Tuberculosis			_____