YOUTH WITH A MISSION

Please mail completed forms to Youth With A Mission — Cebu PO Box 26, 6045 Talisay City, Cebu, Philippines

MEDICAL FORM

TO THE APPLICANT: This form is treated confidentially. Please answer all questions in ink or TYPE IN ENGLISH. *(part B. is to be completed by your Physician)*

NAME: _____ Social Security Number: _____
Last First Middle

School or ministry you are applying for _____ Med. Ins. No. _____

A. PERSONAL HISTORY

Please answer all questions. Comment on all positive answers in the space below or on a separate sheet.

Have you ever had, or do you have, any of the following?

	YES	NO
Eye trouble		
Ear trouble		
Head Injury		
Recurrent headache		
Epilepsy		
Fainting Spells		
Weakness		
Paralysis		
Insomia		
Allergy		
Penicillin		
Sulfonamides		
Food's (Specify)		
Other (Specify)		
Mental or Nervous Disorder		

	YES	NO
Skin Condition		
Shortness of breath		
Hay Fever/Asthma		
Heart Trouble		
High blood pressure		
Low blood pressure		
Rheumatism		
Arthritis		
Back problems		
Dislocation of joints		
Broken bones		
Surgery		
Appendectomy		
Tonsillectomy		
Hernia repair		
Other-specify		

	YES	NO
Stomach/Ulcer		
Gall bladder		
Jaundice		
Hepatitis		
Intestinal Troubles		
Recurrent Diarrhea		
Diabetes		
Kidney Disease		
Anemia		
Venereal Disease		
Tumor Cancer		
FEMALES ONLY		
Irregular periods		
Severe cramps		
Excessive flow		
Are you pregnant?		

Comment's _____

Are you at present under a doctor's care for any condition? ☐ NO ☐ YES (Specify) _____

Are you taking any medication at this time? YES NO (Specify) _____

Do you now or have you ever received any compensation for disability from any source? ☐ NO ☐ YES

(Specify) _____

Have you ever had any of the following COMMUNICABLE DISEASES?

	YES	NO
Chicken pox		
Measles (Rubella)		
Measles (Rubeola)		
Mumps		
Hepatitis A or B		

	YES	NO
Pertussis		
Scarlet Fever		
Tuberculosis		
HIV/AIDS		
Other (Specify)		

Have you ever been Tested for TB
☐ Skin Test
☐ Chest X-ray

What vaccinations have you had? _____

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				**Epilepsy, Convulsions**			

Have you ever sought medical help or been treated for: A. Mental emotional disorder B. Depression C. Stress D. Extreme anger

B. PHYSICIAN'S EVALUATION

TO THE PHYSICIAN: PLEASE review the information in part A. Please treat all conditions that you feel require treatment and notify us of any problems that you feel merit follow-up by the Health Service.

HEIGHT _____ (Inches) WEIGHT _____ (Lbs) ☐ Over Weight ☐ Under Weight

BLOOD PRESSURE _____ BLOOD TYPE _____
(A, B, AB, O) (R+OR -)

Are there any abnormalities of the following systems? Please Describe

	YES	NO		YES	NO		YES	NO
Head, Ears, Nose, Throat			**Cardiovascular**			**Musculo-skeletal**		
Respiratory			**Eyes**			**Endocrine**		
Trunk & Back			**Teeth**			**Lymphatic**		
Neuro- Psychiatric			**Hernia**			**Skin**		

PHYSICIANS RECOMMENDATION

☐ ACCEPTABLE ☐ LIMITATION (Specify) ☐ NOT ACCEPTABLE

☐ Should Remain in area where adequate medical care is provided.

Physician's Signature _____ Date _____

Physician's Name (Please Print) _____

Address: _____