



วายแวมประเทศไทย  
Youth With A Mission  
Thailand

Foundations for Counseling Ministry (FCM)

P.O. Box 20 Thungsetthi,  
Bangkok, 10263 Thailand  
Tel: +66 2 752 8180 Fax: +66 2 752 8014  
Email: fcmthailand@gmail.com

## HEALTH HISTORY FORM

Applicant's Name \_\_\_\_\_  
Last Name First Name Middle Preferred

School/Program/Position Applying For: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City Prov./State Postal (Zip) Code Country

Phone numbers: \_\_\_\_\_ Email: \_\_\_\_\_  
Daytime Evening

**MEDICAL INSURANCE:** It is mandatory for all applicants to have medical insurance coverage during your time with us.

Name of Insurer: \_\_\_\_\_ Medical Insurance Coverage: \_\_\_\_\_

### PERSONAL HEALTH HISTORY

Please check all that apply. Comment in the space provided below for any checked "yes".

Yes No	Yes No	Yes No
<input type="radio"/> <input type="radio"/> Skin condition	<input type="radio"/> <input type="radio"/> Heart trouble	<input type="radio"/> <input type="radio"/> Kidney disease
<input type="radio"/> <input type="radio"/> Eye trouble	<input type="radio"/> <input type="radio"/> High blood pressure	<input type="radio"/> <input type="radio"/> Anemia
<input type="radio"/> <input type="radio"/> Ear trouble	<input type="radio"/> <input type="radio"/> Low blood pressure	<input type="radio"/> <input type="radio"/> Cancer (specify)
<input type="radio"/> <input type="radio"/> Head injury	<input type="radio"/> <input type="radio"/> Rheumatism/Arthritis	<input type="radio"/> <input type="radio"/> Eating disorders (specify)
<input type="radio"/> <input type="radio"/> Recurrent headaches	<input type="radio"/> <input type="radio"/> Back problems/injury	<input type="radio"/> <input type="radio"/> Allergies (specify)
<input type="radio"/> <input type="radio"/> Epilepsy	<input type="radio"/> <input type="radio"/> Dislocation of joints	<input type="radio"/> <input type="radio"/> Diabetes
<input type="radio"/> <input type="radio"/> Fainting spells	<input type="radio"/> <input type="radio"/> Broken bones (specify)	<input type="radio"/> <input type="radio"/> Sleep walking
<input type="radio"/> <input type="radio"/> Depression (specify)	<input type="radio"/> <input type="radio"/> Ulcer (specify)	<input type="radio"/> <input type="radio"/> Nose bleeds
<input type="radio"/> <input type="radio"/> Weakness	<input type="radio"/> <input type="radio"/> Gall bladder problems	
<input type="radio"/> <input type="radio"/> Paralysis	<input type="radio"/> <input type="radio"/> Surgery (See next page)	<b>FEMALES ONLY</b>
<input type="radio"/> <input type="radio"/> Insomnia	<input type="radio"/> <input type="radio"/> Jaundice	<input type="radio"/> <input type="radio"/> Irregular periods
<input type="radio"/> <input type="radio"/> Shortness of breath, Asthma	<input type="radio"/> <input type="radio"/> Hepatitis	<input type="radio"/> <input type="radio"/> Severe cramps
<input type="radio"/> <input type="radio"/> Hay fever	<input type="radio"/> <input type="radio"/> Recurrent diarrhea	<input type="radio"/> <input type="radio"/> Excessive flow
<input type="radio"/> <input type="radio"/> Motion sickness	<input type="radio"/> <input type="radio"/> Constipation	<input type="radio"/> <input type="radio"/> Are you pregnant?

Please comment on all conditions above indicated "yes": \_\_\_\_\_

Other illness or conditions not listed above: \_\_\_\_\_

Are you at present under the doctor's care for any condition? ☐ No ☐ Yes (specify) \_\_\_\_\_

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

Are you allergic to any drugs? ☐ No ☐ Yes (specify) \_\_\_\_\_

Do you have any food allergies? ☐ No ☐ Yes (specify) \_\_\_\_\_

Are you allergic to bee or wasp stings? ☐ No ☐ Yes (specify) \_\_\_\_\_

Do you have any special diet needs? ☐ No ☐ Yes (specify) \_\_\_\_\_

Do you wear contact lenses or glasses? ☐ No ☐ Yes (specify) \_\_\_\_\_

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

Do you now or have you ever received any compensation for disability from any source? ☐ No ☐ Yes (specify) \_\_\_\_\_

Do you have any physical impairments, handicaps or conditions which could affect you during physical activity or that require special attention? ☐ No ☐ Yes (specify) \_\_\_\_\_

Please rate your overall physical health: ☐ Excellent/Strong ☐ Above Average ☐ Average ☐ Below Average ☐ Poor/Weak

Note: it is unlawful for YWAM staff or volunteers to administer or give out any kind of drugs, either prescription or over the counter. Therefore, if you require any medication to treat a chronic health condition, allergy, etc., please bring it with you (i.e. Tylenol, Ventolin, Ibuprofen, hay fever medication, etc.) If you are allergic to bee or wasp stings (or suspect you may be) you MUST bring your own EpiPen with you.



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## OTHER INFORMATION

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Type \_\_\_\_\_

What time do you usually go to bed ? \_\_\_\_\_ What time do you usually wake up? \_\_\_\_\_

Would you say you are more of a "morning" or a "night" person? \_\_\_\_\_

What do you do for exercise? \_\_\_\_\_ How often? \_\_\_\_\_

## COMMUNICABLE DISEASES

Have you ever been exposed to or do you carry any contagious diseases or infections? ☐ No ☐ Yes (specify) \_\_\_\_\_

Have you ever had any of the following?

Yes No

- ☐ ☐ Chickenpox  
☐ ☐ Scarlet Fever  
☐ ☐ Mumps

Yes No

- ☐ ☐ Measles (specify)  
☐ ☐ Meningitis  
☐ ☐ Other (specify)

Other (specify) \_\_\_\_\_

Have you ever been tested for the following?

HIV or AIDS ☐ No ☐ Yes

If Yes: Results ☐ Negative ☐ Positive

Tuberculosis (TB) ☐ No ☐ Yes

If Yes: Results ☐ Negative ☐ Positive

*I declare that the contents of this confidential reference are correct and true to the best of my knowledge.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Day/Month/Year*

Name: \_\_\_\_\_

*Please print*

Address: \_\_\_\_\_

*Street*

*City*

*Prov./State*

*Postal (Zip) Code*

*Country*

Office Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Please mail your completed reference form to the address below, attention *Personnel*. Feel free to contact us either via phone or email if you have any questions.

Would you like to receive further information about Youth With A Mission? ☐ Yes ☐ No

*Please note: This information is not to be viewed by the applicant, and all information will be kept in confidence.*

## EMERGENCY CONTACT INFORMATION

Full Name: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

Address \_\_\_\_\_

*Street / P.O. Box*

*City*

*Prov./State*

*Postal (Zip) Code*

*Country*

*Daytime Phone*

*Evening Phone*

*Email*

*I certify that all information in this application is complete and accurate:* \_\_\_\_\_ Date: \_\_\_\_\_

*Signature*

*Day/Month/Year*

If the applicant is under 18 years of age, Parent/Guardian's signature is required: \_\_\_\_\_ Date: \_\_\_\_\_

*Signature*

*Day/Month/Year*

**Please return all forms to:**

**YWAM Foundations for Counseling Ministry School (FCM)**

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