

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 a mandatory requirement 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".

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <table border="0"> <tr><td>Yes</td><td>No</td><td></td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Skin condition</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Eye trouble</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Ear trouble</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Head injury</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Recurrent headaches</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Epilepsy</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Fainting spells</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Depression (specify)</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Weakness</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Paralysis</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Insomnia</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Shortness of breath, Asthma</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Hay fever</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Motion sickness</td></tr> </table> | Yes | No | | <input type="radio"/> | <input type="radio"/> | Skin condition | <input type="radio"/> | <input type="radio"/> | Eye trouble | <input type="radio"/> | <input type="radio"/> | Ear trouble | <input type="radio"/> | <input type="radio"/> | Head injury | <input type="radio"/> | <input type="radio"/> | Recurrent headaches | <input type="radio"/> | <input type="radio"/> | Epilepsy | <input type="radio"/> | <input type="radio"/> | Fainting spells | <input type="radio"/> | <input type="radio"/> | Depression (specify) | <input type="radio"/> | <input type="radio"/> | Weakness | <input type="radio"/> | <input type="radio"/> | Paralysis | <input type="radio"/> | <input type="radio"/> | Insomnia | <input type="radio"/> | <input type="radio"/> | Shortness of breath, Asthma | <input type="radio"/> | <input type="radio"/> | Hay fever | <input type="radio"/> | <input type="radio"/> | Motion sickness | <table border="0"> <tr><td>Yes</td><td>No</td><td></td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Heart trouble</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>High blood pressure</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Low blood pressure</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Rheumatism/Arthritis</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Back problems/injury</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Dislocation of joints</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Broken bones (specify)</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Ulcer (specify)</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Gall bladder problems</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Surgery (See next page)</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Jaundice</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Hepatitis</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Recurrent diarrhea</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Constipation</td></tr> </table> | Yes | No | | <input type="radio"/> | <input type="radio"/> | Heart trouble | <input type="radio"/> | <input type="radio"/> | High blood pressure | <input type="radio"/> | <input type="radio"/> | Low blood pressure | <input type="radio"/> | <input type="radio"/> | Rheumatism/Arthritis | <input type="radio"/> | <input type="radio"/> | Back problems/injury | <input type="radio"/> | <input type="radio"/> | Dislocation of joints | <input type="radio"/> | <input type="radio"/> | Broken bones (specify) | <input type="radio"/> | <input type="radio"/> | Ulcer (specify) | <input type="radio"/> | <input type="radio"/> | Gall bladder problems | <input type="radio"/> | <input type="radio"/> | Surgery (See next page) | <input type="radio"/> | <input type="radio"/> | Jaundice | <input type="radio"/> | <input type="radio"/> | Hepatitis | <input type="radio"/> | <input type="radio"/> | Recurrent diarrhea | <input type="radio"/> | <input type="radio"/> | Constipation | <table border="0"> <tr><td>Yes</td><td>No</td><td></td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Kidney disease</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Anemia</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Cancer (specify)</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Eating disorders (specify)</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Allergies (specify)</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Diabetes</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Sleep walking</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Nose bleeds</td></tr> </table> <p>FEMALES ONLY</p> <table border="0"> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Irregular periods</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Severe cramps</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Excessive flow</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/></td><td>Are you pregnant?</td></tr> </table> | Yes | No | | <input type="radio"/> | <input type="radio"/> | Kidney disease | <input type="radio"/> | <input type="radio"/> | Anemia | <input type="radio"/> | <input type="radio"/> | Cancer (specify) | <input type="radio"/> | <input type="radio"/> | Eating disorders (specify) | <input type="radio"/> | <input type="radio"/> | Allergies (specify) | <input type="radio"/> | <input type="radio"/> | Diabetes | <input type="radio"/> | <input type="radio"/> | Sleep walking | <input type="radio"/> | <input type="radio"/> | Nose bleeds | <input type="radio"/> | <input type="radio"/> | Irregular periods | <input type="radio"/> | <input type="radio"/> | Severe cramps | <input type="radio"/> | <input type="radio"/> | Excessive flow | <input type="radio"/> | <input type="radio"/> | Are you pregnant? |
| Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Skin condition | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Eye trouble | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Ear trouble | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Head injury | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Recurrent headaches | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Epilepsy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Fainting spells | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Depression (specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Weakness | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Paralysis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Insomnia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Shortness of breath, Asthma | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Hay fever | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Motion sickness | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Heart trouble | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | High blood pressure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Low blood pressure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Rheumatism/Arthritis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Back problems/injury | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Dislocation of joints | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Broken bones (specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Ulcer (specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Gall bladder problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Surgery (See next page) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Jaundice | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Hepatitis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Recurrent diarrhea | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Constipation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Kidney disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Anemia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Cancer (specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Eating disorders (specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Allergies (specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Diabetes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Sleep walking | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Nose bleeds | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Irregular periods | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Severe cramps | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | Excessive flow | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <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, Ventilin, 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.

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
Tuberculosis (TB) No Yes

If Yes: Results Negative Positive
If Yes: Results Negative Positive

SURGICAL HISTORY

Please list your surgical history:

DATE PERFORMED (month/year)	TYPE OF SURGERY	OUTCOME/LONG-TERM EFFECTS

OTHER INFORMATION

Height _____ Weight _____ Blood Type _____

What time do you typically go to bed at? _____ What time do you typically wake up? _____

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

What do you do for exercise? _____ How often? _____

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 signature is required: _____ Date: _____
Signature *Day/Month/Year*



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