NORTHWEST CHAPEL

ADULT MEDICAL HISTORY FORM

Missions Ministry Team

Date_____

Name_____ Home Phone_____

Address_____ Mobile Phone_____

City_____ State_____ Zip_____

Occupation_____

Date of Birth_____ ___M ___F Weight_____ ____Single ____Married

Name of Spouse_____ Closest relative_____ Phone_____

If you are completing this form for another person, what is your relationship to that person? _____

Medical Insurance Information

Name of Medical Insurance Company _____ Phone _____

Medical Insurance ID Number _____ Group Number _____

Name of Policy Holder _____

For the following questions, circle *yes* or *no*, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? Yes No
2. Has there been any change in your general health within the past year? Yes No
3. My last physical exam was on _____.
4. Are you currently under the care of a physician? Yes No
   If so, what is the condition being treated? _____
5. The name and address of my physician is:

6. Have you had any serious illness, operation, or hospitalization in the last 5 years? Yes No
   If so, what was the problem? _____
7. Are you taking any prescription or non-prescription medications? Yes No
   If so, what are you taking?_____
   _____

8. Do you currently have, or have you had in the past, any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease? Yes No

b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)? Yes No
   1. Do you have chest pain upon exertion? Yes No
   2. Are you ever short of breath after mild exercise or when lying down? Yes No
   3. Do your ankles swell? Yes No
   4. Do you have inborn heart defects? Yes No
   5. Do you have a cardiac pacemaker? Yes No

c. Allergies? Yes No
d. Sinus trouble? Yes No
e. Asthma or hay fever? Yes No
f. Fainting spells or seizures? Yes No
g. Persistent diarrhea or recent weight loss? Yes No
h. Diabetes? Yes No
i. Hepatitis, jaundice, or liver disease? Yes No
j. AIDS or HIV infection? Yes No
k. Thyroid problems? Yes No
l. Respiratory problems, emphysema, bronchitis, etc.? Yes No
m. Arthritis or painful, swollen joints? Yes No
n. Stomach ulcer or hyperactivity? Yes No
o. Kidney trouble? Yes No
p. Tuberculosis? Yes No
q. Persistent cough or cough that produces blood? Yes No
r. Persistent swollen glands in neck? Yes No
s. Low blood pressure? Yes No
t. Sexually transmitted disease? Yes No
u. Epilepsy or other neurological disease? Yes No
v. Problems with mental health? Yes No
w. Cancer? Yes No
x. Problems of the immune system? Yes No

9. Have you had abnormal bleeding? Yes No
   a. Have you ever required a blood transfusion? Yes No
10. Do you have any blood disorder such as anemia? Yes No
11. Have you ever had any treatment for a tumor or growth? Yes No
12. Are you allergic or have you had a reaction to:
   a. Local anesthetics? Yes No
   b. Penicillin or other antibiotics? Yes No
   c. Sulfa drugs? Yes No
   d. Barbiturates, sedatives, or sleeping pills? Yes No
   e. Aspirin? Yes No
   f. Iodine? Yes No
   g. Codeine or other narcotics? Yes No
   h. Other _____
13. Do you have any disease, condition, or problem not listed above that you think should be mentioned? Yes No
   If so, explain _____
14. Do you wear contact lenses? Yes No
15. Do you wear removable dental appliances? Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold the Northwest Chapel staff responsible for any errors or omissions that I may have made in the completion of this form.

_____
SIGNATURE