PERSONAL HEALTH HISTORY

Full name (as on passport) ____

Nickname/name you want to be called _______________________

Date of birth _________________ Occupation/Student _____________________

Address ________________________________ City ____________________

State _______ Zip _________ Phone ________________ Email ____________

Home Church ____

Nearest relative _______________________________________

Relation to you ______________________ Phone number of relative __________

Allergies ____

Any medical problems? ____

Any emotional problems? ____

Currently under Doctors Care/for what? ___________________________________

List any medications you are now taking __________________________________

Have you ever experienced any of the following medical problems?

Aids/HIV ( )	Heart Problems ( )	Diabetes ( )	Stroke ( )
TB ( )	Polio ( )	Tumors ( )	Asthma ( )
Allergies ( )	Liver Disease ( )	Seizures ( )	Bleeding ( )
Rheumatic fever ( )	Frequent Infections ( )	Heat exhaustion ( )	

Other ( )

Please explain if you checked any of the above.

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