CONFIDENTIAL HEALTH FORM

ywampenang
CLASSROOM: ASIA

A

TO THE APPLICANT: This information is treated confidentially. Please answer all questions in ink or type IN ENGLISH. *Arrange to complete **Part B** through your physician.*

School/ Ministry you are enrolling in: .....

Mr/Mrs/Miss (Last/First): .....

Permanent Address/PO Box: .....

.....

City: ..... State/Province: .....

Zip/Postal Code: ..... Country: .....

Phone: ..... Fax: .....

E-mail: .....

Present Address/PO Box: .....

.....

City: ..... State/Province: .....

Zip/Postal Code: ..... Country: .....

Phone: ..... Fax: .....

E-mail: .....

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?
If YES, please check box and indicate approximate dates.

- ☐ Skin Conditions
- ☐ Eye Trouble
- ☐ Ear Trouble
- ☐ Head Injury
- ☐ Recurrent Headache
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Mental or Nervous Disorders
- ☐ Eating Disorder (s)
- ☐ Paralysis
- ☐ Insomnia
- ☐ Sulphonamides
- ☐ Surgery (specify)
- ☐ Allergies (specify)
- ☐ Food Allergies (specify)
- ☐ Hay Fever
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Heart Trouble
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Rheumatism/Arthritis
- ☐ Back Problems
- ☐ Dislocation of Joints
- ☐ Broken Bones
- ☐ Appendectomy
- ☐ Tonsillectomy
- ☐ Hernia Repair
- ☐ Stomach/Duodenal Ulcer
- ☐ Gall Bladder Problems
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Hyperglycemia / Hypoglycemia
- ☐ Intestinal Troubles
- ☐ Recurrent Diarrhoea
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Anaemia
- ☐ Venereal Disease
- ☐ Tumour/Cancer
- ☐ HIV/AIDS
- ☐ Other (specify)

FEMALES ONLY

- ☐ Irregular Periods
- ☐ Severe Cramps
- ☐ Excessive Flow
- ☐ Are you Pregnant?

YWAM Penang • P.O. Box 451 • 10750 Penang, Malaysia • Tel: 6.04.899.0663 • Tel/Fax: 6.04.890.2214 • E-Mail: SBS-Penang@msn.com

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PLEASE ANSWER THE FOLLOWING QUESTIONS *(Attach additional sheets as needed):*

Are you at present under the doctor's care for any condition?
☐ No ☐ Yes *(Please explain)* .....

Are you taking any medication at this time?
☐ No ☐ Yes *(Please explain)* .....

Do you now or have you ever received any compensation for disability from any source?
☐ No ☐ Yes *(Please explain)* .....

Have you ever sought treatment for any form of mental illness?
☐ No ☐ Yes *(Please explain)* .....

Have you ever struggled with an eating disorder or been approached by others concerned that you have an eating disorder? Have you ever been treated for an eating disorder?
☐ No ☐ Yes *(Please explain)* .....

HAVE YOU EVER HAD ANY OF THE FOLLOWING COMMUNICABLE DISEASES?
(If yes, please give dates)

Chickenpox ☐ No ☐ Yes .....
Scarlet Fever ☐ No ☐ Yes .....
Measles (Rubella) ☐ No ☐ Yes .....
Tuberculosis ☐ No ☐ Yes .....
Mumps ☐ No ☐ Yes .....
Pertussis *(Whooping Cough)* ☐ No ☐ Yes .....
Other (Specify) .....

FAMILY HISTORY

HAVE YOU OR ANY OF YOUR RELATIVES HAD ANY OF THE FOLLOWING?
(If yes, please describe fully)

Tuberculosis ☐ No ☐ Yes
.....

Diabetes ☐ No ☐ Yes
.....

Kidney Disease ☐ No ☐ Yes
.....

Heart Disease ☐ No ☐ Yes
.....

Arthritis ☐ No ☐ Yes
.....

Stomach Disease ☐ No ☐ Yes
.....

Asthma, Hay Fever ☐ No ☐ Yes
.....

Epilepsy, Convulsions ☐ No ☐ Yes
.....

Mental Illness ☐ No ☐ Yes
.....

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B

THIS SECTION OF THE FORM IS TO BE FILLED OUT BY THE PHYSICIAN

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 services.

Height (inches): ..... **Weight (lbs.):** .....

Overweight? ..... **Underweight?** .....

Blood Pressure: ..... **Color Perception:** .....

ARE THERE ANY ABNORMALITIES OF THE FOLLOWING SYSTEMS? If yes, please describe fully.

Eyes	☐ No	☐ Yes	.....
Teeth	☐ No	☐ Yes	.....
Neuro-Psychiatric	☐ No	☐ Yes	.....
Cardiovascular	☐ No	☐ Yes	.....
Respiratory	☐ No	☐ Yes	.....
Trunk and Back	☐ No	☐ Yes	.....
Hernia	☐ No	☐ Yes	.....
Musculoskeletal	☐ No	☐ Yes	.....
Endocrine	☐ No	☐ Yes	.....
Lymphatic	☐ No	☐ Yes	.....
Skin	☐ No	☐ Yes	.....
Head	☐ No	☐ Yes	.....
Ears, Nose, & Throat	☐ No	☐ Yes	.....
Pelvic	☐ No	☐ Yes	.....

PHYSICIAN'S RECOMMENDATION (Indicate one)

☐ Acceptable without limitations.
☐ Acceptable with limitations. (Specify)
☐ Not Acceptable.
☐ Should remain in areas where adequate medical care is provided.

PHYSICIAN'S SIGNATURE: ..... **DATE:** .....

Physician's Name (Please print): .....

Address: .....

.....

Phone: .....

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