YOUTH WITH A MISSION
Las Vegas

Confidential Health Form

Name: _____
Date of Birth (Day/Month/Year): _____ Age: _____
Permanent Address: _____
_____
Phone Number: _____
In case of emergency, contact: _____ Relationship: _____
Address: _____
_____
Home Phone Number: _____ Work Phone Number: _____

1. Blood Type: _____ 2. Height (ft./cm): _____ 3. Weight (lbs./kg): _____
4. Rate your health: Very Good Good
   Average Below Average Other: _____

5. Do you have any objection to using medical services? Yes No
   If yes, please explain: _____
6. Have you struggled with any eating disorders (anorexic, bulimic, compulsive)? Yes No
   If yes, please describe: _____
7. List all important past surgeries, X-rays, illnesses, injuries, or handicaps and briefly explain:
_____
_____
8. Please describe any special dietary needs: _____
   Does this limit you in any way? _____
9. Date of last medical examination: _____
10. Do you drink alcoholic beverages? Yes No
    If yes, how often? _____ What quantity? _____
11. Do you smoke? Yes No Are you willing to quit? Yes No
12. Are you presently taking any medication? Yes No
    If yes, name of drug: _____
    For what ailment or condition? _____
13. Do you ever have trouble sleeping? Yes No
    If yes, please describe: _____
14. Have you ever had a severe emotional upset, or been diagnosed with a mental illness (i.e. depression or other mental illness)? If yes, please describe: _____
_____
15. Have you ever had suicidal thoughts or attempts? Yes No
    If yes, please comment: _____
16. Have you ever used drugs for anything other than medical purposes or abused prescription medication? If yes, when? Name of drug(s)? _____ For how long? _____

17. Are you pregnant? Yes No If yes, when is your due date?_____
Have you been pregnant before? Yes No

18. Have you been tested for HIV? Yes No Did you test positive or negative?_____

19. Have you ever had or do you have any of the following?
If yes, please describe on a separate sheet of paper:

Allergy to:		
Food - *specify*	Yes	No
Penicillin	Yes	No
Selfonamides	Yes	No
Serum	Yes	No
Other - *specify*	Yes	No
Anemia	Yes	No
Asthma	Yes	No
Back Problems	Yes	No
Broken Bones	Yes	No
Diabetes	Yes	No
Dislocation of joints	Yes	No
Ear trouble	Yes	No
Epilepsy	Yes	No
Eye Trouble	Yes	No
Fainting Spells	Yes	No
Gall Bladder Problems	Yes	No
Hay Fever	Yes	No
Head Injury	Yes	No
Heart Condition	Yes	No
Hepatitis	Yes	No
*What type?*_____		
High or Low Blood Pressure	Yes	No
Insomnia	Yes	No
Intestinal Trouble	Yes	No
Jaundice	Yes	No
Kidney Disease	Yes	No
Migraines	Yes	No
Nervous Disorders	Yes	No
Paralysis	Yes	No
Recurring Diarrhea	Yes	No
Rheumatism/Arthritis	Yes	No
Shortness of Breath	Yes	No
Skin Condition	Yes	No
Stomach/duodenal ulcer	Yes	No
Tumor/Cancer	Yes	No
Venereal Disease	Yes	No
*Which one?*_____		
Weakness	Yes	No

20. Have you ever had any of the following communicable diseases?

Chicken Pox	Yes	No
Measles (Rubella)	Yes	No
Measles (Rubeola)	Yes	No
Mumps	Yes	No
Pertussis	Yes	No
Scarlet Fever	Yes	No
Tuberculosis	Yes	No

Other, please specify: _____

_____

21. Immunization Record

			Date (Month/Year)
BCG	Yes	No	_____
Cholera	Yes	No	_____
DPT.Td (series of 3)	Yes	No	_____
Measles (Rubeola)	Yes	No	_____
Measles (Rubella)	Yes	No	_____
Polio (series of 3)	Yes	No	_____
Polio	Yes	No	_____
Smallpox	Yes	No	_____
Td Booster	Yes	No	_____
Tetanus Booster	Yes	No	_____
Typhoid (series of 3)	Yes	No	_____
Yellow Fever	Yes	No	_____

22. Have any of your relatives ever had any of the following?

			Relationship
Arthritis	Yes	No	_____
Asthma, Hay Fever	Yes	No	_____
Diabetes	Yes	No	_____
Epilepsy	Yes	No	_____
Heart Disease	Yes	No	_____
Kidney Disease	Yes	No	_____
Stomach Disease	Yes	No	_____