Youth With A Mission – Ventura California USA

CONFIDENTIAL HEALTH FORM A: PERSONAL HISTORY

TO THE APPLICANT: This information is treated as confidential. Please print or type answers to ALL questions in English. Although your responses to these questions will not necessarily affect acceptance considerations, certain medical conditions may preclude acceptance. Your physician or physician's assistant must complete form B. (Other health forms done for other YWAM bases are not acceptable.)

First Name: _____ DOB:_____
Middle Name: _____
Last/Family Name: _____
Birth Place: _____
Please rate your health: ____Excellent ____Good ____Fair ____Poor
Do you have medical insurance? ____Yes ____ No If Yes, Name of Insurer: _____
Insurance #: _____ Insurer Phone: _____
Type of Coverage (briefly):
_____

Please answer all questions. Take both Form A and Form B to your physician. Comment on all "yes" answers on a separate sheet of paper. The omission of health history problems or incomplete explanation of the same can lead to removal of acceptance status. Have you ever had any of the following?

Please explain any other illnesses, conditions, or surgeries you have had or are going through currently:
_____
_____
_____
Are you presently under a doctor's care for any condition? ____Yes ____ No
Specify: _____
Are you presently taking any medication? ____Yes ____ No
Specify: _____
Are you allergic to any medication/drugs? ____Yes ____ No
Specify: _____

Do you have a history of emotional instability or psychiatric treatment? ____Yes ____ No
If "Yes", when: _____ For how long: _____
Still in treatment? ____Yes ____ No

Please explain:
_____
_____
_____
_____

Do you have any history with: Eating disorders: ___Yes ___ No Drug or alcohol abuse: ___Yes ___ No

Sexual issues: ___Yes ___ No If "Yes" to any above, when: _____
For how long: _____ Currently? ____Yes ____ No
Please explain:
_____
_____
_____

Do you have any physical impairments, handicaps, or health conditions, which require special attention?
____Yes ____ No

Specify:_____

Have you been tested for HIV/AIDS? ____Yes ____ No

Have you been diagnosed as having HIV/AIDS? ____Yes ____ No

*** FEMALES ONLY:** Do you currently have any of the following?

Please Answer: NO / YES

Irregular Periods_____ Severe Cramps_____ Excessive Flow_____
Pregnant? Due date_____

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CONFIDENTIAL HEALTH FORM B: PHYSICIAN'S EVALUATION

Applicant's Name: _____ Date of Application: _____

TO THE PHYSICIAN: Please review the information in Form 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 service. Some conditions such as diabetes, epilepsy and heart disease may have an effect on the location of the applicant's outreach. Please ensure that any pertinent information in these areas has been included.

TO THE APPLICANT: All the following immunizations MUST BE COMPLETED BEFORE YOU WILL BE ACCEPTED AT YWAM–Ventura: Diphtheria, Tetanus, Typhoid, Polio, Measles, Mumps, Rubella, Hepatitis A, Hepatitis B. (Due to the varied outreach locations, other immunizations, injections and malaria medication may be required and can be obtained before outreach.) Please be prepared financially to cover the cost of additional injections. You need to have a Diphtheria-Tetanus booster within the last 5 years. If you were born after 1957, you will need a measles booster (total of 2 measles immunizations). Those born before 1957 are considered immune from measles.

Diphtheria (day) _____(month) _____(year) _____ (day)_____(month) _____(year) _____
Hepatitis A (day) _____(month) _____(year) _____ (day)_____(month) _____(year) _____
Hepatitis B (day) _____(month) _____(year) _____ (day)_____(month) _____(year) _____
Measles (day) _____(month) _____ (year) _____ (day)_____(month) _____(year) _____
Mumps (day) _____(month) _____(year) _____ (day)_____(month) _____(year) _____
Polio (day) _____(month) _____(year) _____ (day)_____(month) _____(year) _____
Rubella (day) _____(month) _____(year) _____ (day)_____(month) _____(year) _____
Tetanus (day) _____(month) _____(year) _____ (day)_____(month) _____(year) _____
Typhoid (day) _____(month) _____(year) _____ (day)_____(month) _____(year) _____

____Chest X-ray Date: _____ Result: _____ Examination Facility:_____
____TB Skin Test Date: _____ Result: _____ Examination Facility:_____

Height: _____/_____ Weight: _____ Overweight: _____
Blood Pressure:_____Pulse: _____ Blood Type: _____

Urinalysis: _____ A1C _____

Last Mammogram:_____ Last Pap Smear (not compulsory): _____

Visual Acuity: (without glasses) R_____ L_____ (with corrective lenses) R_____ L_____
Auditory Acuity: R_____ L_____ Other_____

Please Answer: NO / YES

Recurrent Headaches_____ Fainting Spells_____ Shortness of Breath_____ Weakness_____
Heart Trouble_____ Hepatitis_____ Jaundice_____ Recurrent Diarrhea_____ Intestinal Troubles_____
Kidney Disease_____ Diabetes_____ Venereal Disease_____ Anemia_____ High Blood Pressure_____
Low Blood Pressure_____ Rheumatism/Arthritis____ Paralysis____ Back Problems___ Dislocation of Joints

Please Answer: NO / YES

Insomnia_____ Tumor/Cancer_____ Skin Condition_____ Eye Trouble_____ Ear Trouble_____
Allergy: Food (specify)_____ Allergy: Bee Stings_____ Allergy: Penicillin_____
Allergy: Serum_____ Allergy: Sulfonamides_____ Asthma_____ Hay Fever_____ Head Injury_____
Mental/ Nervous Disorders_____ Gall Bladder Problems_____ Stomach/Duodenal Ulcer _____
Epilepsy_____ Broken Bones_____ Surgeries_____

COMMUNICABLE DISEASES: Have you ever had any of the following?

Please Answer: NO / YES

Chicken Pox_____ Measles (Rubella)_____ Measles (Rubeola)_____ Mumps_____ Pertussis_____
Scarlet Fever_____ Tuberculosis _____ Other (specify) _____

Are there any abnormalities of the following systems? Please describe fully.

E. N. T. _____
Ophthalmological_____
Teeth _____
Neurological _____
Cardiovascular _____ __
Respiratory _____
Musculoskeletal_____
Endocrine _____
Lymphatic_____
Dermatological_____
Hernial Orifices _____
Urological _____
Psychiatric _____
Other:_____
Recommendations For Follow-up Tests / Treatment: _____

Would he/she be able to walk 3 – 4 miles per day? ____Yes ____ No
Comment:
_____
_____

FOR WOMEN ONLY:

Please Answer: NO / YES

Does the patient have any problems with her menstrual cycle? ____Yes ____No
If yes, please explain: _____
_____
_____

Is the applicant pregnant? ____Yes _____No
If so, when is the baby due? Day _____ Month _____ Year _____

Past pregnancies? ____Yes ____No
If so, what was the outcome?_____
_____

PHYSICIAN'S RECOMMENDATION: ____ Acceptable w/o Limitations ____ Not Acceptable
____ Should Be Where Adequate Medical Care Is Provided ____Acceptable with Limitations (specify)
_____
Additional Comments:
_____
_____
_____

How long has this patient attended your office? Years_____ Months_____ Weeks_____

PHYSICIAN'S NAME: (print) _____DATE: _____

ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE: _____

PHYSICIAN'S SIGNATURE:

_____DATE_____