



Adventures In Missions

3723 34th St. • Lubbock, TX 79410 • 1-800-658-9553 • fax (806) 793-2043 • info@aimsunset.org • www.aimsunset.org

REPORT OF MEDICAL HISTORY

To the applicant: Please complete pages 1 and 2 *before* going to your physician for a physical examination. Then take all four pages with you to your physical. Your physician will complete page 3. Page 4 provides extra space for more details, if needed.

Note: This information is strictly for the use of the AIM program and will not be released to anyone without your knowledge and consent.

APPLICANT INFORMATION

NAME

Last Name First Name Middle Applicant Phone Number

ADDRESS

Street City State/Province ZIP/Postal Code

OTHER DETAILS

Citizenship Date of Birth Male Female

FAMILY HISTORY

Relationship	Age	State of Health	Occupation
Father			
Mother			
Brothers			
Sisters			

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

Type of Illness	Yes	No	Relationship	Additional Comments
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		
Asthma, Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>		
Epilepsy, Convulsions	<input type="checkbox"/>	<input type="checkbox"/>		
Cancer, Tumor, Cyst	<input type="checkbox"/>	<input type="checkbox"/>		

PERSONAL HISTORY

Have you ever had the following? Please check "Yes" or "No" for each condition.

Sinusitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pain/Pressure in chest	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Disease or injury of joints	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Eye trouble	<input type="checkbox"/>	<input type="checkbox"/>	Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Knee problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Back problems	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Weakness, paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or intestinal trouble	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>

Please explain about any of the above conditions for which you checked "Yes." Use additional space on page 4 if necessary.

PERSONAL HISTORY (CONT.)

Have you ever:

If yes, please explain in detail (use additional space on page 4 if necessary):

- Had seizures Yes No _____
- Had fainting spells Yes No _____
- Had an eating disorder Yes No _____
- Had breathing problems Yes No _____
- Had psychiatric counseling Yes No _____
- Had chronic illness Yes No _____
- Had cancer or a tumor Yes No _____
- Had insomnia Yes No _____
- Frequent anxiety/nervousness Yes No _____
- Frequent depression Yes No _____

Within the last two years have you ever:

If yes, please explain in detail (use additional space on page 4 if necessary):

- Had psychiatric counseling Yes No _____
- Been sexually active Yes No _____
- Taken medication for an emotional disorder Yes No _____
- Taken medication for depression Yes No _____
- Had a significant gain or loss of weight Yes No _____
- Had ADD or ADHD Yes No _____
- Struggled with violence or anger Yes No _____
- Had difficulty making new friends Yes No _____
- Had any thoughts of suicide Yes No _____
- Intentionally inflicted pain or injury on yourself (cutting, etc.) Yes No _____

Are you a vegetarian? Yes No If yes, for how long? _____ If yes, please give the reasoning behind your decision:

(Please note that you may need to eat meat as a part of cultural sensitivity)

Are you currently taking any prescription medication? Yes No If yes, give details (name, dosage, reason for use):

Do you use any non-prescription drugs on a regular basis? Yes No If yes, give details:

Do you have any physical impairment? Yes No If yes, give details:

I understand I am applying to be a missionary apprentice and will likely encounter difficult living conditions and stressful situations. I have answered this form completely truthful.

Applicant's Signature: _____ **Date:** _____

REPORT OF HEALTH EVALUATION

To the examining physician: Please review the applicant's history on pages 1 and 2, then complete the information below.

BASIC HEALTH INFORMATION

Blood Pressure: _____ / _____ Height: _____ Weight: _____

Corrected Vision: Right 20 / _____ Left 20 / _____

IMMUNIZATION (Required by Texas law)

Diphtheria - Tetanus (TD adult type - within 10 years) Yes No Date of injection (required): _____

HEALTH DETAILS

Does the applicant have abnormalities of:

If yes, please describe fully (use additional space on page 4 if necessary):

Head, ears, nose, or throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Respiratory	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cardiovascular	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Gastrointestinal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Musculoskeletal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Metabolic / Endocrine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Neuropsychiatric	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Skin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

Further questions (please comment on all "Yes" answers; use additional space on page 4 if necessary):

Is there loss or seriously impaired function of any paired organ?

Yes No If yes, please explain: _____

Does the applicant have any form of epilepsy?

Yes No If yes, please explain: _____

Is the applicant a diabetic?

Yes No If yes, please explain: _____

Do you have any recommendations regarding the care of this applicant?

Yes No If yes, please explain: _____

Is the applicant now under treatment for any medical or emotional condition?

Yes No If yes, please explain: _____

OVERALL ASSESSMENT

How would you rate the applicant's overall physical condition?

Poor Health 1 2 3 4 5 Great Health

PHYSICIAN

Physician's name (please print): _____ Physician's signature: _____

Physician's mailing address: _____
Street City State/Province ZIP/Postal Code

Date: _____

