Confidential Health Form 1

Name_____Applying for_____

Complete Address_____

E-mail address_____

Location of YWAM Base_____Date of Program/Arrival_____

Personal History

Please answer all questions. Explain any "YES" answers in the space below. Show this form to your physician before he fills out Health 2

HAVE YOU EVER HAD, OR DO YOU HAVE, ANY OF THE FOLLOWING? (Circle Yes or No):

Skin Conditions	Yes/No	Epilepsy	Yes/No	Ear trouble	Yes/No
Rheumatism/Arthritis	Yes/No	Recurrent diarrhea	Yes/No	High blood pressure	Yes/No
Hepatitis	Yes/No	Jaundice	Yes/No	Low blood pressure	Yes/No
Hay Fever, Asthma	Yes/No	Head injury	Yes/No	Heart trouble	Yes/No
Recurrent Headaches	Yes/No	Intestinal trouble	Yes/No	Gall bladder problems	Yes/No
Fainting spells	Yes/No	Back problems	Yes/No	Stomach/Duodenal Ulcer	Yes/No
Diabetes	Yes/No	Mental disorders	Yes/No	Eye trouble	Yes/No
Dislocation of joints	Yes/No	Kidney Disease	Yes/No	Tumor: Cancer	Yes/No
Nervous disorders	Yes/No	Broken bones	Yes/No	HIV/AIDS	Yes/No
Anemia	Yes/No	Weakness	Yes/No	Venereal Disease	Yes/No
Eating disorders	Yes/No	Insomnia	Yes/No	Shortness of breath	Yes/No
Bulimia	Yes/No	Paralysis	Yes/No	Anorexia Nervosa	Yes/No
Allergies to:		**Surgeries:**		**Females Only:**	
Penicillin	Yes/No	Appendectomy	Yes/No	Irregular Periods	Yes/No
Sulfonamides	Yes/No	Tonsillectomy	Yes/No	Severe cramps	Yes/No
Serum	Yes/No	Hernia repair	Yes/No	Excessive flow	Yes/No
Food-Specify	Yes/No	Others-Specify	Yes/No	Are you pregnant?	Yes/No
Others-Specify	Yes/No				

Other/Explain _____

Have you ever had any of the following COMMUNICABLE DISEASES?

__Chickenpox __Measles (Rubella) __Mumps __Pertussis __Scarlet Fever __Tuberculosis

Are you under a doctor's care for any reason? __Yes __No (Specify)

_____

Are you taking any medication at this time? __Yes __No (Specify) _____

Do you have any physical handicaps or health conditions which require special attention? __Yes __No (Specify)

_____

Do you have any history of emotional instability or psychiatric treatment? __Yes __No (Specify)_____