NORTHWEST ◻ CHAPEL

Medical History Form for Child

Missions Ministry Team

Today's Date: _____

Name _____ Home Phone _____

Address _____ Business Phone _____
Number, Street

City _____ State _____ Zip Code _____

Date of Birth _____ Sex ____M ____ F Weight _____
month/day/year

Closest Relative _____ Phone _____

If you are completing this form for another person, what is your relationship to that person? _____

Medical Insurance Information

Name of Medical Insurance Company _____ Telephone Number _____

Medical Insurance ID Number _____ Group Number _____

Name of Policy Holder _____

For the following questions, *circle yes or no*, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? Yes No
2. Has there been any change in your general health within the past year? Yes No
3. My last physical exam was on:
4. Are you now under the care of a physician? Yes No
   If so, what is the condition being treated?
5. The name and address of my physician is:

6. Have you had any serious illness, operation, or been hospitalized in the last 5 years? Yes No
   If so, what was the problem?
7. Are you taking any medicine(s) including non-prescription medicine? Yes No
   If so, what medicine(s) are you taking?
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease? Yes No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis,stroke)? Yes No
      1. Do you have chest pain upon exertion? Yes No
      2. Are you ever short of breath after mild exercise or when lying down? Yes No
      3. Do your ankles swell? Yes No
      4. Do you have inborn heart defects? Yes No
      5. Do you have a cardiac pacemaker? Yes No
   c. Allergy Yes No
   d. Sinus trouble Yes No
   e. Asthma or hay fever Yes No
   f. Fainting spells or seizures Yes No
   g. Persistent diarrhea or recent weight loss Yes No

h.	Diabetes		Yes	No
i.	Hepatitis, jaundice or liver disease		Yes	No
j.	AIDS or HIV infection	Yes	No	
k.	Thyroid problems		Yes	No
l.	Respiratory problems, emphysema, bronchitis, etc.	Yes	No	
m.	Arthritis or painful swollen joints	Yes	No	
n.	Stomach ulcer or hyperactivity	Yes	No	
o.	Kidney trouble		Yes	No
p.	Tuberculosis		Yes	No
q.	Persistent cough or cough that produces blood	Yes	No	
r.	Persistent swollen glands in neck	Yes	No	
s.	Low blood pressure	Yes	No	
t.	Sexually transmitted disease	Yes	No	
u.	Epilepsy or other neurological disease	Yes	No	
v.	Problems with mental health	Yes	No	
w.	Cancer		Yes	No
x.	Problems of the immune system	Yes	No	
9.	Have you had abnormal bleeding?	Yes	No	
	a. Have you ever required a blood transfusion?	Yes	No	
10.	Do you have any blood disorder such as anemia?	Yes	No	
11.	Have you ever had any treatment for a tumor or growth?	Yes	No	
12.	Are you allergic or have you had a reaction to:			
a.	Local anesthetics		Yes	No
b.	Penicillin or other antibiotics	Yes	No	
c.	Sulfa drugs		Yes	No
d.	Barbiturates, sedatives or sleeping pills?	Yes	No	
e.	Aspirin		Yes	No
f.	Iodine		Yes	No
g.	Codeine or other narcotics		Yes	No
h.	Other			
13.	Do you have any disease, condition, or problem not listed above that you think I should be aware of?		Yes	No
	If so, explain.			
14.	Are you wearing contact lenses?	Yes	No	
15.	Are you wearing removable dental appliances?	Yes	No	

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold the Northwest Chapel staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

Parent Signature