

# NORTHWESTCHAPEL

## ADULT MEDICAL HISTORY FORM

*Missions Ministry Team*

Date \_\_\_\_\_

Name \_\_\_\_\_

Home Phone \_\_\_\_\_

Address \_\_\_\_\_

Mobile Phone \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Occupation \_\_\_\_\_

Date of Birth \_\_\_\_\_

\_\_\_M \_\_\_F

Weight \_\_\_\_\_

\_\_\_Single \_\_\_Married

Name of Spouse \_\_\_\_\_

Closest relative \_\_\_\_\_

Phone \_\_\_\_\_

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

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### Medical Insurance Information

Name of Medical Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Medical Insurance ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

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**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 currently 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 hospitalization in the last 5 years? Yes    No  
If so, what was the problem? \_\_\_\_\_
7. Are you taking any prescription or non-prescription medications? Yes    No  
If so, what are you taking? \_\_\_\_\_  
\_\_\_\_\_
  
8. Do you currently have, or have you had in the past, 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. Allergies?	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 should be mentioned? Yes	No	
If so, explain _____		
14. Do you wear contact lenses?	Yes	No
15. Do you wear removable dental appliances?	Yes	No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires 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.

\_\_\_\_\_  
SIGNATURE