Youth With A Mission

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## Relief and Development Services Tanzania- Morogoro Centre

P.O. Box 6123 * Morogoro * TANZANIA * East Africa

# CONFIDENTIAL HEALTH FORM

TO THE APPLICANT: This information is treated as confidential. Please print of type answers to all questions. As certain medical conditions preclude acceptance please complete the whole form. PART B must be completed by your physician. Less inclusive medicals done for YWAM bases are no acceptable.

Name _____ Date of Birth _____
(Last) (First) (Middle)
Permanent Address (Street / PO Box): _____

City _____ State / Province _____ Zip / Postal Code _____

Phone _____

Nearest Relative _____ Relationship _____

Address of nearest relative (Street / PO Box): _____

City _____ State / Province _____ Zip / Postal Code _____

Phone _____ Emergency Phone number _____

**PART A** (Personal History): Please answer all of the questions and take both Part A and Part B to your doctor. Comment on all positive answers in the space below or on a separate sheet of paper. Have you ever had, or do you currently have any of the following?

| | NO | YES | | NO | YES | | NO | YES |
|---|---|---|---|---|---|---|---|---|
| Skin conditions | | | High blood pressure | | | Jaundice | | |
| Eye trouble | | | Low blood pressure | | | Hepatitis | | |
| Ear trouble | | | Allergic reaction to: | | | Intestinal trouble | | |
| Head injury | | | Penicillin | | | Recurrent diarrhoea | | |
| Recurrent epilepsy | | | Sulphonamides | | | Diabetes | | |
| Epilepsy | | | Serum | | | Kidney disease | | |
| Fainting spells | | | Foods - Specify | | | Anaemia | | |
| Nervous disorders | | | Heart trouble | | | STD / Venereal disease | | |
| Weakness | | | Rheumatism / arthritis | | | Tumour / Cancer | | |
| Paralysis | | | Back problems | | | FEMALE ONLY: | | |
| Insomnia | | | Dislocation of joints | | | Irregular periods | | |
| Shortness of breath | | | Broken bones | | | Severe cramps | | |
| Hay fever | | | Stomach/duodenal ulcer | | | Excessive flow | | |
| Asthma | | | Gall bladder problems | | | Are you pregnant? | | |
| | | | | | | Previous pregnancies | | |

## PART B:

TO THE PHYSICIAN: Please review the information in part A. Please treat all conditions that you feel require treatment and notify us of any problems you feel merit follow-up. As certain conditions such as severe diabetes, epilepsy, heart disease and severe obesity preclude from acceptance, please ensure that these have been excluded.

Height_____Weight_____Overweight☐ Blood pressure_____
Pulse_____Blood Group_____Rh Factor_____
E.C.G. (If over 40)_____
Visual Acuity R_____L_____Without glasses
R_____L_____with glasses or contacts
Colour Perception_____
Hearing R_____L_____
Urinalysis_____last Pap Smear (not compulsory)_____

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

| | NO | YES | PLEASE DESCRIBE |
|---|---|---|---|
| E.N.T. | | | |
| OPHTHAMOLOGICAL | | | |
| TEETH | | | |
| NEUROLOGICAL | | | |
| CARDIOVASCULAR | | | |
| RESPIRATORY | | | |
| MUSKULOSKELETAL | | | |
| ENDOCRINE | | | |
| LYMPHATIC | | | |
| HERNIA ORIFICES | | | |
| GYNAECOLOGICAL | | | |
| UROLOGICAL | | | |
| PSYCHIATRIC | | | |

Recommendations for follow-up test/treatment:_____
_____

Additional comments:_____
_____

PHYSICIAN'S RECOMMENDATION: PHYSICIAN'S NAME: (print)_____

☐Acceptable without limitations ADDRESS:_____

☐Acceptable with limitations (specify)_____

☐Not Acceptable: should remain in areas where adequate medical care is provided.

_____
Physician's signature Date

NOTE: **Tunaomba ucheck na HIV na utakaporudisha fomu, utume majibu haya pia.(We request you do an HIV test also and let us know the results). This helps us as we are living in a community and doing different activities & duties**

SURGERIES PERFORMED

| DATE | TYPE OF SURGERY | OUTCOME & LONG TERM EFFECTS |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

X-RAYS PERFORMED

| DATE | TYPE OF X-RAY | RESULT |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Are you at present under a doctor's care for any condition? ☐NO ☐YES—Specify_____

Please arrange to bring along all necessary long-term medications with you as continuing supplies may not be available. Do you know or have you ever received any worker's compensation or disability from any sources?

☐NO ☐YES—Specify_____

Have you ever had any of the following COMMUNICABLE DISEASES?

| | NO | YES | | | NO | YES |
|---|---|---|---|---|---|---|
| Chicken Pox | | | Pertussis | Mumps | | |
| Measles(Rubella) | | | Scarlet Fever | Other-specify | | |
| Measles (Rubeola) | | | Tuberculosis | | | |

IMMUNISATION RECORD

| IMMUNISATION | DATE | IMMUNISATION | DATE |
|---|---|---|---|
| DPT/DT* | | | |
| | | | |
| | | | |
| | | | |

Tetanus Booster is required if not done in the last five years.

FAMILY HISTORY

| | | | |
|---|---|---|---|
| Tuberculosis | | | |
| Diabetes | | | |
| Kidney Disease | | | |
| Heart Disease | | | |
| Arthritis | | | |
| Stomach Disease | | | |
| Asthma/Hay fever | | | |
| Epilepsy/Convulsions | | | |