Health Inventory Medical Form

Last Name: _____ First:_____ Middle:_____ Male ☐ Female ☐ Birthdate:_____
Address:_____City:_____ State: _____ Zip: _____
Phone:_____ Marital Status: Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐
Employed by or Student of _____ Phone: ( ) _____ – _____
Address:_____City:_____ State: _____ Zip: _____

In Case of Emergency

1. Other Nearest relative at Home: Name _____ Relationship _____ Phone ( ) _____–_____
2. Name of Another Person: Name _____ Relationship _____ Phone ( ) _____–_____
   Address:_____ City:_____ State:_____ Zip:_____
3. Name of Physician: _____ Phone ( ) _____–_____
   Address:_____ City:_____ State:_____ Zip:_____

Insurance Information

Name of Insurance: _____Individual or Family Coverage: _____
Group #: _____ Certificate #:_____ Medicare #:_____
Policy issued in what State: _____ Policy Holder's Name: _____ Phone: _____
Will this policy cover you overseas? YES ☐ NO ☐

Personal History

NOTE: This is a confidential record of your medical history and will only be used in case of an emergency.

Illness: Have you ever had . . . ?	YES	NO	Illness: Have you ever had . . . ?	YES	NO
High or Low Blood Pressure	☐	☐	Hypertension	☐	☐
Gout	☐	☐	Hyperactivity/ADD/ADHD	☐	☐
Nephritis (Bright's Disease)	☐	☐	Infectious disease	☐	☐
Diabetes	☐	☐	Insect stings allergy *Anaphylaxis	☐	☐
Kidney Disease or Stones	☐	☐	Joint/back or limb pain	☐	☐
Bladder Disease	☐	☐	Arthritis or other conditions	☐	☐
Anxiety or Depression	☐	☐	Kidney or liver disease	☐	☐
Appendicitis	☐	☐	Menstrual problems	☐	☐
Allergies/Sinus problems	☐	☐	Nervous condition/depression	☐	☐
Asthma/persistent cough	☐	☐	Nose problems/Bleeding	☐	☐
Bleeding Disorder	☐	☐	Physical Disability	☐	☐
Convulsions/fainting	☐	☐	Serious illness	☐	☐
Epilepsy/convulsion/fainting	☐	☐	Serious injury	☐	☐
Eye/ear problems	☐	☐	Skin/gland problems	☐	☐
Frequent ear infections	☐	☐	Sleepwalking	☐	☐
Gall Bladder problems	☐	☐	Stomach/bowel problems	☐	☐
Heart defect/disease	☐	☐	Tuberculosis	☐	☐
Hernia	☐	☐	Ulcers (stomach/intestines)	☐	☐
Hives or Eczema	☐	☐	Mumps/Chicken Pox	☐	☐
Cancer	☐	☐	Emotional problems	☐	☐
Migraine Headaches	☐	☐	Swelling of hands, feet or ankles	☐	☐
Nervous Breakdown	☐	☐	Abnormal X-rays/ blood-work results	☐	☐
Do you smoke?	☐	☐	Learning Disabilities	☐	☐

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Allergy: Are you allergic to any drugs?	YES	NO	Allergy : Are you allergic to any drugs?	YES	NO
Mycins or other Antibiotics	☐	☐	Penicillin or Sulfa	☐	☐
Latex	☐	☐	Aspirin, Codeine, or Morphine	☐	☐
Mycins or other Antibiotics	☐	☐	Other (Please List)	☐	☐

Family History

(If Living) (If Deceased)

Name	Age	Health	Age at death	Cause (if known)	YES	Check if any blood relative has ever had any of the following?	Who
Father					☐	Cancer	
Mother					☐	Mental Illness	
Brother/Sister:					☐	Asthma	
					☐	Stroke	
					☐	Heart Trouble	
					☐	High Blood Pressure	
Children:					☐	Diabetes	
					☐	Tuberculosis	
					☐	Birth Defects	

Explain any "Yes" items and list any other problems, including the diagnosis, date of injury or illness, hospital, length of hospitalization, name of doctor, etc. List any exposure to infectious disease in the month prior to departure.

_____

_____

_____

_____

Special or Prescription Medications:

Please list any medication being taken or prescribed for occasional use including the name and phone number of the prescribing physician, dosage, consumption rate and interval.

Name of Medication	***Dosage***	***Frequency***	***Prescribing Physician & Number***
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Special Restrictions:

Chronic or recurring illness and treatment which may be needed: _____

_____

_____

_____

Dietary modifications require physician's written instructions to be given to Extend Global staff three (3) weeks prior to the departure.

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