

Health Inventory Medical Form

NOTE: Please fill out the fillable PDF and email to teams@extendglobal.org.

Last Name: _____ First: _____ Middle: _____ Male Female Birthday: _____
 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.

<u>Name of Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Prescribing Physician & Number</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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.

