



Health Education Africa Resource Team

CONFIDENTIAL MEDICAL QUESTIONNAIRE TEAM MEMBER MEDICAL INFORMATION

The information on this form will be used in the event of a crisis or emergency and will remain in the possession of a HEART staff member. Please give full disclosure. This is for your protection in the event of an emergency.

Name of Team Member _____ Phone # _____
Team Member's D.O.B. _____ Team Dates _____

Family Doctor's Name _____ Phone # _____
Family Doctor's Address _____

- | | | |
|---|-----|----|
| 1) Is a doctor currently treating you? | Yes | No |
| 2) Do you have any condition requiring special medical consideration? | Yes | No |
| 3) Psychological or emotional disorders, limitations? | Yes | No |
| 4) Have you sustained any injury that may limit physical activity? | Yes | No |
| 5) Are you on a special diet that has been prescribed by a doctor? | Yes | No |
| 6) Have you had major surgery in the past 3 years? | Yes | No |

If answered yes for any of the above, please explain. (Attach a separate sheet of paper if necessary)

List all medications you use. This includes medication you are taking for this trip. Provide information on dosage, frequency, and reason for using all medication:

Medication/Dosage	Frequency	Reason for usage

List any known allergies: medicine (penicillin, aspirin, iodine, acetaminophen, sulfa, other drugs); foods (dairy, wheat, other foods); contact with substances (plants, soaps, other substances); animals, insect bites/stings.

Allergy	Reaction	Medication/Treatment

Has your reaction ever required emergency room care? _____

Please list any current health problems _____

Blood Type _____

Do you smoke? _____

Condition	Yes	No	Condition	Yes	No
Anemia			Asthma		
Bleeding Problems			Emphysema		
Cancer			High Blood Pressure		
Malaria			Heart Disease		
Tuberculosis			Stroke		
+HIV (Aids) Positive			Seizures/Epilepsy		
Peptic Ulcers			Psychiatric Illness		
Diabetes			Alcoholism		
Drug Abuse			Other		

If answered yes for any of the above, please explain in detail:

List previous surgeries:

Procedure	Year	Reason

List serious accidents/injuries

Injury	Year	Treatment

List other serious illnesses/hospitalizations

Illness	Year	Treatment

Check immunizations, which you have previously received:

Immunization	Year	Update
Tetanus -Diphtheria Booster		
MMR		
Polio Booster		
Hepatitis A (Two?)		
Hepatitis B (All Three?)		
Typhoid		
Meningococcal		
Influenza		
Rabies		
Yellow Fever		
Varicella		
Others		

Signature _____

Date _____

Please sign and return to:

HEART Office
P.O. Box 631964
Highlands Ranch, CO 80163-1964
(303) 730-3779