

CONFIDENTIAL

If the answer is "yes" to any of the following, enter the details in the space provided indicating the diagnosis, date of illness, name of hospital, length of hospitalization, name of doctor, etc.

	YES	NO
1 NERVOUS OR MENTAL Problems such as epilepsy, emotional stress, convulsions, loss of consciousness, dizziness, paralysis, Frequent anxiety, excessive crying. <i>If yes, please explain:</i>		
2 LUNG DISEASE Asthma, blood spitting, persistent cough, tuberculosis, abnormal chest x-rays. <i>If yes, please explain:</i>		
3 DISEASE OR HEART OR BLOOD VESSELS, INCREASED OR ABNORMAL BLOOD PRESSURE <i>If yes, please explain:</i>		
4 PAIN IN THE CHEST OR SHORTNESS OF BREATH Heart murmur, rheumatic fever <i>If yes, please explain:</i>		
5 STOMACH OR INTESTINAL TROUBLE Ulcers, gall bladder or liver disorders, jaundice, hernia, colitis. <i>If yes, please explain:</i>		
6 ARTHRITIS, DIABETES, KIDNEY OR BLADDER DISEASE <i>If yes, please explain:</i>		
7 HAY FEVER OR ALLERGIES <i>If yes, please explain:</i>		
8 ALLERGIES TO MEDICINES (including Penicillin, Tetanus) <i>If yes, please explain:</i>		

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9 IMPAIRED SIGHT OR HEARING, CHRONIC EAR INFECTIONS *If yes, please explain:*

10 RECENT SURGICAL OPERATIONS, ACCIDENTS OR INJURIES *If yes, please explain:*

11 BEEN A PATIENT IN A HOSPITAL (other than #10) *If yes, please explain:*

12 ANY INFECTIOUS DISEASE OR CONTACT WITH INFECTIOUS DISEASE IN THE TWO WEEKS PRIOR TO THIS TRIP. *If yes, please explain:*

13 SKIN DISEASE *If yes, please explain:*

14 ALLERGY TO FOODS *If yes, please explain:*

15 MEDICATIONS YOU ARE CURRENTLY TAKING (list name and doses) *If yes, please explain:*

16 UNDER ON-GOING CARE OF A PHYSICIAN FOR CHRONIC OR RECURRING PROBLEM (Name and number of physician) *If yes, please explain:*

17 DATE OF LAST FLU SHOT: _____

18 DATE OF LAST TETANUS BOOSTER: _____

19 LIST ANY SPECIAL NEEDS OR CONCERNS
(Attach additional page if need more space)