PHYSICIAN'S EVALUATION

Dear Doctor, _____(Applicants Name) has applied for service with Youth with a Mission.Youth with a Mission sends volunteers into remote locations around the world where medical treatment and services are limited, at best. Volunteers are sometimes exposed to uncommon risk to health, safety and welfare.

Applicants will be subjected to physical and emotional stresses that they may have never encountered before. They may be living in close quarters with up to 4 roommates, with the probability of temperatures in excess of 30C(86F) for long periods of time. The usual workday is eight hours long and is often strenuous both physically and emotionally. Please REVIEW the applicant's "Personal Health History" and perform a thorough physical examination. Perform any diagnostic tests you feel are appropriate, and please COMPLETE this form. Please COMMENT on any concerns you may have as they relate to the applicant's ability to tolerate physical and emotional conditions in developing nations.

How long has the applicant attended your office? years,_____months_____, just today_____

Height (in cm.) _____ Weight (in kilos.) _____ Age_____

Blood Pressure_____ Pulse_____ Blood Type O A B AB + - (Circle One)

Visual Acuity: (no lenses) R:20/ L:20/ (with) R:20/ L:20/ Color Perception: Normal: Yes/ No

Hearing: R: Normal – Yes/No L: Normal – Yes/No

Is the applicant currently on any medication: Yes/No

Has the applicant taken any medication for longer than one month in the past 5 years Yes/No (prescription or nonprescription)

(Please arrange to bring all necessary long-term medication with you, as supplies may not be available. Except for very new medicines, most are available in Jamaica.)

ARE THERE ANY ABNORMALITIES OF THE FOLLOWING SYSTEMS? IF YES, PLEASE DESCRIBE FULLY.

___ Dermatological
___ Head/Neck
___ Ear/Nose/Throat
___ Ophthalmologic
___ Mouth/Teeth
___ Lymphatic

___ Respiratory
___ Cardiovascular
___ G.I.
___ Urological
___ Genito-Reproductive
___ Musculoskeletal
___Neurological
___ Psychiatric
___ Endocrine

Recommendations for follow-up test/treatment.
PHYSICIAN'S RECOMMENDATION: (Please check one)
___Accept
___Accept with limitations: (please comment on back)
___No Do Not accept (Comment on back)
Physician's Signature:_____
Date:_____
Printed Name:_____
Phone:_____
Fax:_____
Please bring original to the school with you.

CONFIDENTIAL PERSONAL HEALTH HISTORY

NAME:

PLEASE ANSWER ALL QUESTIONS. BRIEFLY COMMENT ON ALL “YES” ANSWERS.

Have you ever had any of the following?

_____Skin conditions
_____Gall bladder problems
_____High blood pressure
_____Recurrent headache
_____Eye trouble
_____Intestinal problems
_____Low blood pressure
_____Fainting spells
_____Ear trouble
_____Recurrent diarrhea
_____Kidney disease
_____Nervous disorders
_____Head injury
_____Heart trouble
_____Weakness
_____Stomach/Duodenal ulcer
_____Anemia
_____Jaundice
_____Paralysis
_____Epilepsy
_____Rheumatism/Arthritis
_____Hepatitis
_____Insomnia
_____Dislocation of joints
_____Tumor/Cancer
_____Diabetes
_____Shortness of breath
_____Eating disorder
_____Back problems
_____Broken bones
_____Hay fever
_____HIV
_____Venereal disease
_____Surgery (Specify)
_____Allergies (Specify)
_____Medications (Specify)

FEMALES ONLY:

_____Irregular periods
_____Severe cramps
_____Excessive flow
_____Previous pregnancies
_____Are you pregnant?

FAMILY HISTORY: Have any members of your immediate family ever had any of the following? If yes, give relationship.

_____Tuberculosis Relationship_____
_____Diabetes Relationship_____
_____Arthritis Relationship_____
_____Asthma/Hay Fever Relationship_____
_____Kidney Disease Relationship_____
_____Stomach Disease Relationship_____
_____Epilepsy/Convulsions Relationship_____

Other Health Issues: Explain: (include reason, results & dates)

_____Do you wear glasses/contact lenses?

_____Have you had any medical tests done in the past 5 years (x-rays, blood test, scan, EKG, brain scan, ultrasound)?

_____Have you been off work or worked partially restricted for more than 14 days for medical reasons?

_____Do you feel you have any disease or condition that would limit your normal daily living condition?