

VOLUNTEER MEDICAL REVIEW



FIRST NAME _____

LAST NAME _____

DATE _____

Thank you for taking time to complete this physical assessment. The purpose of this form is to make you aware of some of the physical aspects of our project, and to provide the project leaders with a concise record of your medical history.

PAST AND PRESENT MEDICAL ISSUES

	Yes	No		Yes	No		Yes	No
1. High Blood Pressure	<input type="radio"/>	<input type="radio"/>	11. Neck Problem	<input type="radio"/>	<input type="radio"/>	21. Medical Equip. / Devices	<input type="radio"/>	<input type="radio"/>
2. Heart Disease	<input type="radio"/>	<input type="radio"/>	12. Back Problem	<input type="radio"/>	<input type="radio"/>	22. Allergies	<input type="radio"/>	<input type="radio"/>
3. Irregular Heartbeat	<input type="radio"/>	<input type="radio"/>	13. Arm Problem	<input type="radio"/>	<input type="radio"/>	23. Chest Pain/Pressure	<input type="radio"/>	<input type="radio"/>
4. Seizure Disorder	<input type="radio"/>	<input type="radio"/>	14. Shoulder Problem	<input type="radio"/>	<input type="radio"/>	24. Unexplained Sweating	<input type="radio"/>	<input type="radio"/>
5. Bleeding Disorder	<input type="radio"/>	<input type="radio"/>	15. Knee Problem	<input type="radio"/>	<input type="radio"/>	25. Frequent Shortness of Breath	<input type="radio"/>	<input type="radio"/>
6. Asthma	<input type="radio"/>	<input type="radio"/>	16. Ankle Problem	<input type="radio"/>	<input type="radio"/>	26. Frequent Dizziness	<input type="radio"/>	<input type="radio"/>
7. Diabetes	<input type="radio"/>	<input type="radio"/>	17. Leg Problem	<input type="radio"/>	<input type="radio"/>	27. Frequent Fainting	<input type="radio"/>	<input type="radio"/>
8. Cancer	<input type="radio"/>	<input type="radio"/>	18. Foot Problem	<input type="radio"/>	<input type="radio"/>	28. Heartburn	<input type="radio"/>	<input type="radio"/>
9. Headaches	<input type="radio"/>	<input type="radio"/>	19. Pregnant	<input type="radio"/>	<input type="radio"/>	29. Intolerance to warm temps	<input type="radio"/>	<input type="radio"/>
10. Stomach Ulcers	<input type="radio"/>	<input type="radio"/>	20. Special Diet	<input type="radio"/>	<input type="radio"/>	30. Other, including surgeries	<input type="radio"/>	<input type="radio"/>

If you answered "yes" to any of the above items, please explain in the chart below. Include these points:

- How you **care** for symptom/condition
- **Medications** taken
- How symptom/condition **restricts your activity**, including your ability to run, lift, or climb

ITEM NO.	DETAILED DESCRIPTION (INCLUDING RESTRICTIONS, IF ANY)

IMMUNIZATIONS RECORD

IMMUNIZATION	DATE LAST IMMUNIZED
Tetanus (required)	

When preparing for your Maranatha project, please make sure you take an ample supply of your prescribed medication in the containers in which they were prescribed. Also, consider taking medications for ailments that occur infrequently, such as an inhaler for occasional asthma attacks. Strenuous exercise and varying weather conditions can sometimes exacerbate dormant conditions.

IN CASE OF EMERGENCY, CONTACT: _____ PHONE: _____