# MEDICAL QUESTIONNAIRE

**NAME:** _______________________________________________________**DOB**: ________________________

Information on this medical form will not be shared with anyone, without your expressed consent. Some questions may not apply to you. In that case, you may leave them blank.

**AGE:**_____ (If a Minor, give Parents Name)_____________________________________________________

**Name of Medical Doctor:**______________________ **Insurance Provider:**____________________

**Are you vaccinated against COVID-19? Yes________ No _________**
**(At this time, vaccinations are required to travel to Ghana, and COVID-testing is also required.)**

## PAST MEDICAL HISTORY

## ILLNESSES:

Yes_____ No_____ High blood pressure
Yes_____ No_____ Diabetes
Yes_____ No_____ Heart problems
Yes_____ No_____ Cancer (type)
Yes_____ No_____ Stroke
Yes_____ No_____ Blood clots

Other:___________________________________________________

**CURRENT MEDICATIONS**

| Name | Amount and frequency taken | Name | Amount and frequency taken |
|---|---|---|---|
| __________ | ________________________ | __________ | _________________________ |
| __________ | ________________________ | __________ | _________________________ |
| __________ | ________________________ | __________ | _________________________ |

**HERBAL, VITAMIN OR NUTRITIONAL THERAPIES**

| Name | Amount and frequency taken | Name | Amount and frequency taken |
|---|---|---|---|
| __________ | ________________________ | __________ | _________________________ |
| __________ | ________________________ | __________ | _________________________ |
| __________ | ________________________ | __________ | _________________________ |

**ALLERGIES**

| Medication or substance | Describe reaction or symptom |
|---|---|
| __________________________________ | ___________________________________ |
| __________________________________ | ___________________________________ |

**PAST SURGERIES (check those that you have had)**

| | DATE (year) | DATE (year) |
|---|---|---|
| ______Heart | ___________ | ___________ |
| ______Liver or Kidney | ___________ | ___________ |
| ______Cancer | ___________ | ___________ |
| Other:_______________ | ___________ | ___________ |

**SOCIAL HISTORY**

Occupation ____________________________________________

Where do you currently live? _City_______________: State:_______________

Do you smoke cigarettes now? Yes ____ No: ___

**HEALTH REVIEW (last 3 months):**

| | YES | NO |
|---|---|---|
| **GENERAL:** | | |
| Weight change, greater than 5 lbs? | _____ | _____ |
| Persistent fatigue: | _____ | _____ |
| **SKIN:** | | |
| Any new skin rashes, lumps or bumps? | _____ | _____ |
| Hot flashes? | _____ | _____ |
| **EYES:** | _____ | _____ |
| Recent vision change? | _____ | _____ |
| Wear Glasses? | _____ | _____ |
| **MOUTH:** | | |
| Sore throat? | _____ | _____ |
| Sore mouth? | _____ | _____ |
| **NECK:** | | |
| New lumps? | _____ | _____ |
| Thyroid problems? | _____ | _____ |
| **LUNGS:** | | |
| Cough? | _____ | _____ |
| Shortness of breath? | _____ | _____ |
| **HEART:** | | |
| Chest pain? | _____ | _____ |
| Ever been told you had a heart murmur? | _____ | _____ |
| Abnormal EKG? | _____ | _____ |
| **GASTROINTESTINAL:** | | |
| Nausea or vomiting? | _____ | _____ |
| Any liver or colon problems? | _____ | _____ |
| **JOINTS / EXTREMITIES:** | | |
| Ever had a blood clot? | _____ | _____ |
| **NEUROLOGIC:** | | |
| Have you ever had a seizure? | _____ | _____ |
| Do you have weakness of an arm, leg or other part of your body? | _____ | _____ |
| **BLOOD:** | | |
| Any history of anemia or blood disorder? | _____ | _____ |
| **PSYCHOLOGICAL:** | | |
| Have you ever been treated for depression or anxiety? | _____ | _____ |