

Health Information Report



Instructions. As part of the application process with Assemblies of God World Missions, please do the following:

- (1) Schedule a comprehensive medical exam for each member of your family.
- (2) Complete Section 1 of this document for each member of your family and print hard copies of each.
- (3) Provide hard copies to your physician at your appointment, and request he/she complete Section 2.
- (4) Submit completed forms to your application specialist (scan and submit using <https://secure3.ag.org/uploads>, or mail to AGWM Personnel and Member Care, 1445 North Boonville Avenue, Springfield, MO 65802, marked "Personal and Confidential").

Section 1: To Be Completed by the Patient

Patient _____ Head of Household _____ Today's Date _____
 DOB _____ Height _____ Weight _____
 Physician's Name _____ Physician's Phone _____

Allergies (medications, food, environmental)

Current Medications/ Vitamins/Supplements	Purpose	Available In-Country or Special Handling/Storage Requirement

Immunizations	Date	*	Immunizations (continued)	Date	*
Diphtheria/tetanus/acellular pertussis (DTaP)		<input type="checkbox"/>	Tetanus/diphtheria/acellular pertussis (TDaP)		<input type="checkbox"/>
Diphtheria/tetanus		<input type="checkbox"/>	Tetanus/diphtheria		<input type="checkbox"/>
Haemophilus influenza type B		<input type="checkbox"/>	Varicella		<input type="checkbox"/>
Hepatitis A		<input type="checkbox"/>	Typhoid fever		<input type="checkbox"/>
Hepatitis B		<input type="checkbox"/>	Yellow fever		<input type="checkbox"/>
Human papillomavirus (HPV)		<input type="checkbox"/>	Combination Vaccines		<input type="checkbox"/>
Influenza (inactivated)		<input type="checkbox"/>	DTaP/hepatitis B/inactivated poliovirus		<input type="checkbox"/>
Measles/mumps/rubella (MMR)		<input type="checkbox"/>	DTaP/inactivated poliovirus/haemophilus influenza type B		<input type="checkbox"/>
Meningococcal serogroups A/C/Y/W		<input type="checkbox"/>	DTaP/inactivated poliovirus		<input type="checkbox"/>
Meningococcal serogroup B		<input type="checkbox"/>	Measles/mumps/rubella/varicella (MMRV)		<input type="checkbox"/>
Pneumococcal 13-valent conjugate		<input type="checkbox"/>	Other Vaccines (list)		<input type="checkbox"/>
Poliovirus (inactivated)		<input type="checkbox"/>			<input type="checkbox"/>
Rotavirus		<input type="checkbox"/>			<input type="checkbox"/>
Shingles (newest)		<input type="checkbox"/>			<input type="checkbox"/>

*Note when a series is complete by adding a check mark after the date field for each immunization.

Surgeries/Major Illnesses/Accidents	Approx. Date

Special Medical Equipment/Supplies	Powered?	Maintenance Requirements

Medical Problems

- | | | |
|---|--|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> G6PD deficiency (malarial areas) | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Allergies, seasonal | <input type="checkbox"/> GERD (acid reflux) | <input type="checkbox"/> Nervous or emotional problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Headaches | <input type="checkbox"/> Osteopenia/osteoporosis |
| <input type="checkbox"/> Arthritis of legs or arms | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart CABG and/or stents | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Artificial joints/screws/plates | <input type="checkbox"/> Heart attack; date: _____ | <input type="checkbox"/> Peptic ulcer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart valve issues | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bladder problems/incontinence | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Pulmonary embolism/DVT/blood clot/
aneurysm |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Immune system problems | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Cancer; type: _____ | <input type="checkbox"/> Infectious mononucleosis | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Injuries to back, arms, legs, or joints | <input type="checkbox"/> Sinus infections |
| <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Skin disorders |
| <input type="checkbox"/> COPD/emphysema/shortness of breath | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Stroke; date: _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Diabetes 1, 2, or abnormal blood sugar | <input type="checkbox"/> Lung disease (other) | <input type="checkbox"/> Suicidal |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Lupus | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Dizziness or fainting spells | <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Measles | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> DVT (blood clot) | <input type="checkbox"/> Migraines | <input type="checkbox"/> Abnormal chest X-ray |
| <input type="checkbox"/> Eating disorder | | |

Other Medical Problems Not Listed Above

Congenital or Chronic Conditions *(also note frequency)*

Audiological Issues *(also note hearing devices)*

Ophthalmological Issues

Dental Issues

Section 2: To Be Completed by the Physician

Patient _____ How long have you known the patient? _____

Please list/explain any of the following regarding the patient:

Limitations to physical activity _____

Seriously under/overweight _____

Permanent injury or disability _____

Health/dietary requirements _____

Anticipated travel hardship _____

(ability to carry luggage, conduct strenuous travel, manage long flights)

Do you believe this patient can physically serve overseas where medical care may be scarce and conditions potentially harsh?

Additional comments:

Physician's office stamp, if available:

Physician's signature

Date

(Please do not send medical records with this form.)