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 _____ Parent/Guardian _____ Today's Date 3/31/21

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

**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

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

Other Medical Problems Not Listed Above

Congenital or Chronic Conditions *(also note frequency)*

Ophthalmological Issues

Audiological Issues (*also note hearing devices)*

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 live and work in locations where medical care may be scarce and conditions potentially harsh?

☐ Yes ☐ No

Additional comments:

Physician's office stamp, if available:

_____ _____

Physician's signature Date

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