

AIM House LLC

MEDICAL HISTORY

Applicant's Name _____

Person Completing Form _____ Relation to Applicant _____

Does applicant wear contact lenses on glasses? _____

If yes, when are they required? reading only in classroom driving all the time

Please attach prescription.

Does the applicant have any problems with speech or hearing? If yes, please explain. _____

Does applicant have any current health problems? If yes, please explain. _____

Dentists Name _____ Date of Last Dental Exam _____

City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

Has the applicant had orthodontic work? _____

Current Orthodontist Name _____

City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

Family Physician's Name _____

City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

List all hospitalizations for medical reasons:

Date _____ Hospital Name _____

Date _____ Hospital Name _____

Date _____ Hospital Name _____

List all hospitalizations for psychiatric reasons:

Date _____ Hospital Name _____

Date _____ Hospital Name _____

Date _____ Hospital Name _____

List all operations:

Date _____ Physician's Name _____

Date _____ Physician's Name _____

Date _____ Physician's Name _____

List all accidents involving applicant:

Date _____ Physician's Name _____

Date _____ Physician's Name _____

Date _____ Physician's Name _____

Has applicant ever broken a bone? Please list. _____

List all drug allergies:

Drug _____ Reaction _____

Drug _____ Reaction _____

Drug _____ Reaction _____

List all food and environmental allergies:

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Please attach separate form if necessary.

List all medications, prescription and over the counter drugs applicant is currently taking. Please note that AIM House does not allow narcotic medication and has a specific approval protocol for certain ADHD medication. Also, not all over counter drugs are allowed.

List all street drugs and alcoholic beverages currently being used or used in the past and approximate amount used on a weekly basis.

Indicate which of the following diseases, illnesses or problems the applicant has had. Please include dates.

- | | |
|---|---|
| <input type="checkbox"/> Red Measles (10 day) - Dates: | <input type="checkbox"/> Venereal Disease - Dates: |
| <input type="checkbox"/> German Measles - Dates: | <input type="checkbox"/> High Blood Pressure - Dates: |
| <input type="checkbox"/> Scoliosis - Dates: | <input type="checkbox"/> Chicken Pox - Dates: |
| <input type="checkbox"/> Mumps - Dates: | <input type="checkbox"/> Diabetes - Dates: |
| <input type="checkbox"/> Whooping Cough - Dates: | <input type="checkbox"/> Dermatitis, Eczema - Dates: |
| <input type="checkbox"/> Epilepsy - Dates: | <input type="checkbox"/> Bone Condition - Dates: |
| <input type="checkbox"/> Scarlet Fever - Dates: | <input type="checkbox"/> Knee Problems - Dates: |
| <input type="checkbox"/> Rheumatic Fever - Dates: | <input type="checkbox"/> Arthritis - Dates: |
| <input type="checkbox"/> Polio - Dates: | <input type="checkbox"/> Frequent Colds, Sore Throats - Dates: |
| <input type="checkbox"/> Convulsions, Seizures - Dates: | <input type="checkbox"/> Ulcers - Dates: |
| <input type="checkbox"/> Meningitis, Encephalitis - Dates: | <input type="checkbox"/> Muscle Weakness - Dates: |
| <input type="checkbox"/> Pneumonia - Dates: | <input type="checkbox"/> Anemia - Dates: |
| <input type="checkbox"/> Heat Disorder - Dates: | <input type="checkbox"/> Frequent Constipation, Diarrhea - Dates: |
| <input type="checkbox"/> Bladder or Kidney Infection - Dates: | <input type="checkbox"/> Frequent Ear Infections - Dates: |

Please list any other significant illnesses, diseases or disorders not listed above. Please include dates.

Have any relatives of the applicant had any of the following conditions:

Tuberculosis	<input type="checkbox"/> no	<input type="checkbox"/> yes	Relation to applicant:
Bleeding Disorders	<input type="checkbox"/> no	<input type="checkbox"/> yes	Relation to applicant:
Epilepsy or Convulsions	<input type="checkbox"/> no	<input type="checkbox"/> yes	Relation to applicant:
Cardiovascular Disease	<input type="checkbox"/> no	<input type="checkbox"/> yes	Relation to applicant:
Diabetes	<input type="checkbox"/> no	<input type="checkbox"/> yes	Relation to applicant:
Kidney Disease	<input type="checkbox"/> no	<input type="checkbox"/> yes	Relation to applicant:
Cancer	<input type="checkbox"/> no	<input type="checkbox"/> yes	Relation to applicant:
High Blood Pressure	<input type="checkbox"/> no	<input type="checkbox"/> yes	Relation to applicant:
Muscle Disorder	<input type="checkbox"/> no	<input type="checkbox"/> yes	Relation to applicant:
Other Illness in Family	<input type="checkbox"/> no	<input type="checkbox"/> yes	Relation to applicant:

Please provide complete immunization history. List the month and year each immunization was given.

Polio	1. _____	2. _____	3. _____	4. _____	5. _____
DPT or TD	1. _____	2. _____	3. _____	4. _____	5. _____
Measles	1. _____	2. _____	3. _____	4. _____	5. _____
Rubella	1. _____	2. _____	3. _____	4. _____	5. _____
Mumps	1. _____	2. _____	3. _____	4. _____	5. _____
TB Test Results	1. _____	2. _____	3. _____	4. _____	5. _____

I certify that all information in this application is true and complete to the best of my knowledge.

Signature of Applicant _____ Date _____

Signature of Preparer _____ Date _____

PHYSICAL EXAMINATION

Required for Enrollment

Name _____ Date _____

Birth Date _____ Age _____ Weight _____ Height _____

Pulse _____ Blood Pressure _____ Eyes _____

Glasses? no yes Fudoscopic _____

Vision R _____ Vision L _____

Ears _____ Nose _____

Throat _____ Neck _____

Chest _____ Heart _____

Abdomen _____ Genitalia _____

Neurological _____ Musculoskeletal _____

Scoliosis _____ Lymph _____

Significant findings or recommendations _____

Are there any physical impairments which would limit this applicant's ability to participate in vigorous physical activities?

Current medical problems under treatment _____

Current continuous prescribed medications and dosages _____

List any contra-indicated medications _____

Suggested over the counter medications for the following symptoms (only listed medications will be allowed):

Fever/Pain:

Hay Fever:

Stuffy Nose:

Cough:

Upset Stomach:

Headache:

Required Lab Tests and Immunizations (Please Attach Results)

TB Skin Test within 1 Year Date _____ Results _____ Treatment _____

•Urinalysis

•Fasting Glucose

•HIV

•Gonorrhea

•CBC with Diff

•Tetanus within 10 years

•VDRL

•Hepatitis B

Physician's Signature _____ **Date** _____ **Phone** _____