

AIM House LLC  
**MEDICAL HISTORY**

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Applicant Name \_\_\_\_\_

Name of person completing application \_\_\_\_\_

If not applicant, relation to applicant \_\_\_\_\_

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Does applicant wear contact lenses on glasses? \_\_\_\_\_

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

Please attach prescription.

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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. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Dentists Name \_\_\_\_\_ Date of Last Dental Exam \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Has the applicant had orthodontic work? \_\_\_\_\_

Current Orthodontist Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

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Family Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

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. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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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.

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

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

Red Measles (10 day) - Dates:

Venereal Disease - Dates:

German Measles - Dates:

High Blood Pressure - Dates:

Scoliosis - Dates:

Chicken Pox - Dates:

Mumps - Dates:

Diabetes - Dates:

Whooping Cough - Dates:

Dermatitis, Eczema - Dates:

- Epilepsy - Dates:
- Scarlet Fever - Dates:
- Rheumatic Fever - Dates:
- Polio - Dates:
- Convulsions, Seizures - Dates:
- Meningitis, Encephalitis - Dates:
- Pneumonia - Dates:
- Heat Disorder - Dates:
- Bladder or Kidney Infection - Dates:
- Bone Condition - Dates:
- Knee Problems - Dates:
- Arthritis - Dates:
- Frequent Colds, Sore Throats - Dates:
- Ulcers - Dates:
- Muscle Weakness - Dates:
- Anemia - Dates:
- Frequent Constipation, Diarrhea - Dates:
- Frequent Ear Infections - Dates:

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

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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. _____

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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*

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Date \_\_\_\_\_

Applicant Name \_\_\_\_\_

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: \_\_\_\_\_

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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 \_\_\_\_\_