International Health Services

Member Health Maintenance – Medical History: Adult Static

Name Last First Middle initial	Today's date					
Address	Male		Female			
	Single		Married		Widowed	
	Birth Date					

Have you previously served overseas:

Where is your current assignment?

Do you plan on changing locations? To where? When?

Are you currently being treated by a physician, and if so for what conditions?

What are your past medical conditions?

What are your current medical problems?

Medications you're taking:

What allergies do you have?

Tests: Enter the approximate year you were last given the test and the result.

Year		
	Chest X-ray	
	Kidney X-ray	
	G.I. Series (gastrointestinal)	
	Colon X-ray	
	Colonoscopy	
	Gallbladder	
	X-ray/ultrasound	
	Electrocardiograph	
	TB Test	
	Other X-ray	
	Mammogram	
	CT Scan or MRI	
	Ultrasound of:	

Comments:

Please note your family's disease history and your history

For immediate relatives (parents, brothers, sisters), indicate who has or has had the condition (e.g., father, mother, 2 brothers, 1 sister). For other relatives (grandparents, aunts, uncles, cousins), indicate only the number who have/had it. For yourself, indicate the approximate year of onset and comments.

How many brothers/ sisters do you have?	**Your Blood Relatives**		**Your Own History**	
	parents/siblings # and relationship	other relative #	Year	Comment
Diabetes-onset before age 45				
Diabetes-onset after age 45				
Goiter or thyroid disease				
Glaucoma				
Allergies or hay fever				
Asthma				
Emphysema				
Tuberculosis				
Heart disease/attack before age 40				
Heart disease/attack after age 40				
High blood pressure				
Stroke before age 50				
Stroke after age 50				
Cancer of the stomach or intestine				
Kidney disease				
Gout				
Arthritis				
Blood/bleeding disorders				
Cancer of the blood/lymph system				
Eczema				
Epilepsy				
Other neurological disease				
Mental/emotional disorder				
Breast cancer – onset before age 50				
Breast cancer – onset after age 50				
Prostatic cancer				
Other Cancers (including skin cancer)				

The remainder of this sheet is referring to YOUR OWN PERSONAL medical history. Put the approximate year in which you last had the disease, vaccine, operation or condition listed below (or attach copies.)

Have you been vaccinated (V) against or had the disease (D)?					
	V/D	Year		V/D	Year
DPT or DT (tetanus) Booster			Hepatitis A		
Pertussis (whooping cough)			Hepatitis B		
Polio			Meningitis		
Chicken pox			Pneumococcal pneumonia		
Measles, Mumps, Rubella			Influenza (flu)		
Have you had the following operations?					
	Y/N	Year		Y/N	Year
Tonsillectomy			Adenoidectomy		
Appendectomy			Heart bypass surgery		
Hysterectomy			Angioplasty		
Breast biopsy			Gallbladder surgery		
Hernia repair			Hemorrhoid surgery		
Prostate surgery			Vasectomy		
Other surgery (write in)					
Have you had or do you have?					
	Y/N	Year		Y/N	Year
Slipped disk			Chronic fatigue Syndrome		
Unconscious for OVER 30 seconds			Fibromyalgia		
Sexually transmitted disease			Trauma/Assault		
Have you previously					
Used tobacco			Average two or more		
Injected street drugs			Alcoholic drinks/day		