Zambia Medical Mission Medical History Form
All information will be kept private. Please return form to:
Zambia Mission, 658 E.N. 21st St., Abilene, TX 79601

Name:______________________________________ DOB:____________________

Date Form Completed:_______________________

Allergies:

1. Known drug allergies? Please list:

   a.,_____________________________ b._____________________________

   c.,_____________________________ d._____________________________

2. Known food allergies? Please list:

   a.,_____________________________ b._____________________________

   c.,_____________________________ d._____________________________

3. Have you had an allergic reaction to any of the following:

   ____Eggs ____Quinilines (Chloroquine, Lariam)
   ____Sulfa drugs ____Pyrimethamine
   ____Antibiotics ____Tetracycline (doxycycline)
   ____Chrysanthemums ____Other:_______________________
   ____Insects

Blood Type: ________________________

Immunizations:

1. Were you born in the United States? Yes___ No____

2. Have you completed the following immunizations?

   a. Hepatitis A Yes____ When__________________No____
   b. Hepatitis B Yes____ When__________________No____
   c. Meningococcal Yes____ When__________________No____
   d. MMR Yes____ When__________________No____
   e. Polio Series Yes____ When__________________No____
   f. Tetanus Yes____ When__________________No____
   g. Typhoid Yes____ When__________________No____
   h. Yellow fever Yes____ When__________________No____
   i. Diptheria Yes____ When__________________No____
   j. Whooping Cough Yes____ When__________________No____
   k. Shingles Yes____ When__________________No____
   l. Other
   ________________ Yes____ When__________________No____

   If “No”, have you ever have measles, mumps, rubella or chicken pox? Yes______ No_______
   If you have, please list____

Medical History:

1. Are you using steroids, receiving immunosuppressive therapy or chemotherapy?
   Yes______ No_______

2. List **all** your current prescription medications and the medical condition treated:

Current prescription medications	Condition or reason for use
a. ______________________________	______________________________
b. ______________________________	______________________________
c. ______________________________	______________________________
d. ______________________________	______________________________
e. ______________________________	______________________________

3. List all regularly used non-prescription medications (over the counter, vitamins, etc):

Regularly used non-prescription medication	Condition or reason for use
a. ______________________________	______________________________
b. ______________________________	______________________________
c. ______________________________	______________________________

4. Have you been told you have any of the following conditions:

Yes	No	Family History		Yes	No	Family History	
____	____	____	Anemia	____	____	____	Hypertension
____	____	____	Asthma	____	____	____	High Cholesterol
____	____	____	Blood Clotting problems	____	____	____	Immune disorder
____	____	____	Cancer	____	____	____	Kidney disorder
____	____	____	Depression	____	____	____	Liver disease
____	____	____	Epilepsy	____	____	____	Lung disease
____	____	____	Ear infections (frequent)	____	____	____	Psychiatric
____	____	____	Eye problems	____	____	____	Psoriasis
____	____	____	Glaucoma	____	____	____	Sickle cell
____	____	____	G6PD deficiency	____	____	____	Stomach ulcer
____	____	____	Gout	____	____	____	Stroke
____	____	____	Hearing Loss	____	____	____	Thyroid disease
____	____	____	Heart disease	____	____	____	Other:____________

5. Surgeries:
   Please list any past surgeries and date (appendectomy, tonsillectomy, etc.)
   ____
   ____

   When was the last time you saw a doctor and what was it for? Date:______________________
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