

Health Information Form

Return form to Lifeline with first payment

Full Name (as appears on passport) _____

Blood Type _____ Past Medical Problems _____

Surgical History _____

Depression or Emotional Problems? (Explain) _____

Currently under doctor's care? (Explain) _____

List any medications you are now taking _____

Disabled? _____ If Yes, list condition(s) & limitations: _____

Have you ever experienced any of the following health problems? If so, when? (Answer Yes with Date or No)

AIDS/HIV _____ Diabetes _____ TB _____ Polio _____ Asthma _____

Heart Problems _____ High Blood Pressure _____ Bleeding _____ Cancer _____

Kidney Disease _____ Liver Disease _____ Broken Bones _____ Seizures _____

Hernias _____ Rheumatic Fever _____ Stroke _____ Heat exhaustion _____

Allergic Reactions to Medication _____ Other Allergies _____

Please explain below if you have answered YES to any of the above _____

Name & Phone of Family Physician _____

Last visit to Physician(s) and reason _____