ANNUNCIATION HOUSE
815 Myrtle
El Paso, TX 79901
(915) 533-4675

MEDICAL REPORT

PLEASE TYPE OR PRINT

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL___
ADDRESS_____ CITY_____ STATE _____ ZIP _____
DATE OF BIRTH _____ AGE _____ SEX _____ PHONE _____

GENERAL INFORMATION

TO BE ANSWERED BY PATIENT

FAMILY HEALTH HISTORY

1. Has any member of your immediate family had tuberculosis, diabetes, high blood pressure, heart illness, stroke or any other significant medical or psychiatric illness? YES _____ NO _____
   If YES, please explain. _____
   _____
   _____

2. Are any members of your immediate family (i.e., parents, siblings or children) deceased? YES ☐ NO ☐
   If YES, which members, what were the causes of their deaths, and what were their ages at death? _____
   _____
   _____

PAST HEALTH HISTORY

1. How often do you usually see a doctor or dentist for check-ups?
   _____
   _____

2. Have you ever been in a hospital or other institution for the purpose of receiving medical or psychological treatment or therapy? YES ____ NO____ If YES please provide dates, name of hospital/institution and cause of hospitalization for each instance. _____
   _____
   _____

3. Record of immunizations—Please give dates of most recent inoculations:
   Polio _____ Measles _____Mumps _____ Rubella _____ Diphtheria _____ Tetanus _____
   Date of most recent TB test: _____ If positive, was chest x-ray taken? YES ___ NO ___
   Result of x-ray: POSITIVE ___ NEGATIVE ___ Was medicine given? YES ___ NO ___

4. Have you ever suffered from any of the following conditions? Please check YES or NO for each.

	YES	NO		YES	NO
1. Diabetes	___	___	23. Stomach pain or ulcer	___	___
2. Tuberculosis	___	___	24. Colitis or enteritis	___	___
3. Asthma	___	___	25. Salmonellosis	___	___
4. Emphysema	___	___	26. Shigellosis	___	___
5. Chronic cough	___	___	27. Parasites in stool	___	___
6. Other lung problems	___	___	28. Hernia	___	___
7. High blood pressure	___	___	29. Other abdominal pain	___	___
8. Heart trouble	___	___	30. Kidney or bladder trouble	___	___
9. Rheumatic fever	___	___	31. Venereal disease	___	___
10. Stroke	___	___	32. Thyroid disease	___	___
11. Endocrine disorders	___	___	33. Anemia	___	___
12. Cancer or tumor	___	___	34. Meningitis	___	___
13. Schizophrenia	___	___	35. Drug addiction	___	___
14. Nervous breakdown	___	___	36. Alcoholism	___	___
15. Other mental disorders	___	___	37. High cholesterol	___	___
16. Migraine headaches	___	___	38. Hepatitis	___	___
17. Nose or throat trouble	___	___	39. Fainting spells	___	___
18. Ear trouble/deafness	___	___	40. Fits or seizures	___	___
19. Head or neck injury	___	___	41. Joint or back trouble	___	___
20. Eye illness or trouble	___	___	42. Typhoid fever	___	___
21. Menstrual problems	___	___	43. Epilepsy	___	___
22. Fracture of any bone	___	___	44. Other	___	___

Please explain all "YES" answers.

_____

_____

_____

_____

5. Has your work or schooling been limited or restricted on account of your health? YES ___ NO ___
   If YES, please explain. _____
   _____
   _____

6. Have you lost time from work or school during the past two years due to illness or injury other than minor colds or flu? YES___ NO ___ If YES, please give number of days lost and explain the circumstances. _____
   _____
   _____

7. Have you had problems with or received any type of medical care or treatment for alcohol or drug abuse? YES ___ NO___ If YES, please give number of days lost and explain the circumstances. _____
   _____
   _____

8. Have you ever had problems with or received any psychological treatment, therapy or counseling for sexual addiction? YES ___ NO ___ If YES, please provide dates and prognosis. _____

PRESENT HEALTH HISTORY

1. Please rate your present health: EXCELLENT _____ GOOD_____ FAIR _____

2. Do you presently have any health problem or condition that requires medical care or medication? YES ____ NO ____ If YES, please explain. _____

3. Are you PRESENTLY taking any prescription medication? YES ____ NO ____ If YES, explain what medication you take and for what condition. _____

4. Do you have any allergies or dietary limitations? YES ____ NO ____ If YES, please explain.

5. Do you have any physical disabilities or limitations? YES ____ NO ____ If YES, please explain.

6. Are you PRESENTLY receiving any type of medical treatment or therapy for any type of addiction or substance abuse? YES ____ NO ____ If YES, please explain. _____

7. Will you need to see a doctor, dentist or psychologist for any reason during the coming year? YES ____ NO ____ If YES, please explain. _____

MEDICAL EVALUATION

TO BE FILLED OUT BY PHYSICIAN

How long has the individual been your patient? _____ Date of exam: _____

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____ PULSE RATE _____

LAB RESULTS (if labs done recently): U/A _____ CBC _____
TB SKIN TEST: POSITIVE ___ NEGATIVE ___ CHEST X-RAY:_____

HEARING:
RIGHT EAR _____ LEFT EAR _____

VISION: (with corrective lenses, if worn):
RIGHT EYE _____ LEFT EYE _____

UPON MEDICAL EXAMINATION, ARE THERE ANY ABNORMALITIES OF THE FOLLOWING:

	YES	NO		YES	NO
1. Ears	____	____	13. Spleen	____	____
2. Nose	____	____	14. Hernial sites	____	____
3. Eyes	____	____	15. Genitalia	____	____
4. Mouth and teeth	____	____	16. Rectum	____	____
5. Throat	____	____	17. Extremities (joints)	____	____
6. Head and neck	____	____	18. Skeletal (scoliosis)	____	____
7. Heart	____	____	19. Reflexes	____	____
8. Chest	____	____	20. Skin and surgical scars	____	____
9. Breasts	____	____	21. Nervous system	____	____
10. Lungs	____	____	22. Lymphatic system	____	____
11. Abdomen	____	____	23. Evidence of mental illness	____	____
12. Liver	____	____	24. Any other abnormalities	____	____

Please elaborate on all "YES" answers or abnormalities:

_____

_____

_____

_____

_____

Is the individual restricted from any activity? YES ____ NO ____ If YES, please indicate:

_____

_____

_____

Conclusion, diagnosis or comments: _____

_____

_____

_____

IDENTIFICATION OF EXAMINING PHYSICIAN: (Please print or use office stamp.)

NAME OF EXAMING PHYSICIAN _____

ADDRESS _____ CITY_____ STATE _____ ZIP _____

PHONE _____

SIGNATURE OF EXAMINING PHYSICIAN _____

RETURN TO: Annunciation House
c/o Coordinator of Volunteers
815 Myrtle Ave.
El Paso, TX 79901
(915) 533-4675