# MEDICAL QUESTIONNAIRE

**NAME:** ______________________________________________**DOB**: ________________________

Information on this medical form <u>will not</u> be shared with anyone, without your expressed consent. Some questions may not apply to you. In that case, you may leave them blank.

**AGE:**_____ (If a Minor, give Parents Name)_____________________________________________________

**Name of Medical Doctor:**_______________________ **Insurance Provider:**_____________________

**Are you vaccinated against COVID-19? Yes**__________ **No** __________

**(As of Dec 12, 2021, vaccinations are required by the Ghanaian government to enter the country in addition to a negative COVID-test.)**

## PAST MEDICAL HISTORY

### ILLNESSES:

Yes_____ No_____ High blood pressure
Yes_____ No_____ Diabetes
Yes_____ No_____ Heart problems
Yes_____ No_____ Cancer (type)
Yes_____ No_____ Stroke
Yes_____ No_____ Blood clots

Other:______________________________________________________

**CURRENT MEDICATIONS**

| Name | Amount and frequency taken | Name | Amount and frequency taken |
|---|---|---|---|
| __________ | _________________________ | __________ | _________________________ |
| __________ | _________________________ | __________ | _________________________ |
| __________ | _________________________ | __________ | _________________________ |

**HERBAL, VITAMIN OR NUTRITIONAL THERAPIES**

| Name | Amount and frequency taken | Name | Amount and frequency taken |
|---|---|---|---|
| __________ | _________________________ | __________ | _________________________ |
| __________ | _________________________ | __________ | _________________________ |
| __________ | _________________________ | __________ | _________________________ |

**ALLERGIES**

| Medication or substance | Describe reaction or symptom |
|---|---|
| ___________________________________ | ____________________________________ |
| ___________________________________ | ____________________________________ |

**PAST SURGERIES (check those that you have had)**

| | DATE (year) | DATE (year) |
|---|---|---|
| ______Heart | ____________ | ____________ |
| ______Liver or Kidney | ____________ | ____________ |
| ______Cancer | ____________ | ____________ |
| Other:________________ | ____________ | ____________ |

**SOCIAL HISTORY**

Occupation _______________________________________________

Where do you currently live? _City________________: State:________________

Do you smoke cigarettes now? Yes ____ No: ___

**HEALTH REVIEW (last 3 months):**

| **GENERAL:** | YES | NO |
|---|---|---|
| Weight change, greater than 5 lbs? | _____ | _____ |
| Persistent fatigue: | _____ | _____ |
| **SKIN:** | | |
| Any new skin rashes, lumps or bumps? | _____ | _____ |
| Hot flashes? | _____ | _____ |
| **EYES:** | _____ | _____ |
| Recent vision change? | _____ | _____ |
| Wear Glasses? | _____ | _____ |
| **MOUTH:** | | |
| Sore throat? | _____ | _____ |
| Sore mouth? | _____ | _____ |
| **NECK:** | | |
| New lumps? | _____ | _____ |
| Thyroid problems? | _____ | _____ |
| **LUNGS:** | | |
| Cough? | _____ | _____ |
| Shortness of breath? | _____ | _____ |
| **HEART:** | | |
| Chest pain? | _____ | _____ |
| Ever been told you had a heart murmur? | _____ | _____ |
| Abnormal EKG? | _____ | _____ |
| **GASTROINTESTINAL:** | | |
| Nausea or vomiting? | _____ | _____ |
| Any liver or colon problems? | _____ | _____ |
| **JOINTS / EXTREMITIES:** | | |
| Ever had a blood clot? | _____ | _____ |
| **NEUROLOGIC:** | | |
| Have you ever had a seizure? | _____ | _____ |
| Do you have weakness of an arm, leg or other part of your body? | _____ | _____ |
| **BLOOD:** | | |
| Any history of anemia or blood disorder? | _____ | _____ |
| **PSYCHOLOGICAL:** | | |
| Have you ever been treated for depression or anxiety? | _____ | _____ |