ADULT MEDICAL HISTORY
LUTHERAN BIBLE TRANSLATORS, INC.

Date _____

GENERAL

Name _____ Occupation _____

Weight _____ Has your weight gone up or down during the past year? _____ How much _____ Height _____

Birthplace _____ Marital status: Single ____ Married _____ Widow _____

Birth date _____ Date of marriage(s) _____

Probable field of service _____ Ages of children, if any _____

Describe your fitness program _____

Among your blood relatives describe any (a) hypertension, (b) arthritis, (c) asthma, (d) diabetes, (e) epilepsy, (f) thyroid Problem, (g) hay fever, (h) heart or any circulatory or blood disease, (i) insanity or any mental disorder, (j) mental retardation, (k) nervous breakdown, (l) recurring sick headaches, (m) tuberculosis, or (n) any genetic disabilities. Specify relative, disease, age when occurred and degree and duration of your contact:

_____

_____

Give the following data about your birth family. Use B or S for brother or sister.

	IF LIVING		IF NOT LIVING					
	Age	Health (well or ill) If not well, give diagnosis	Cause of death	How long ill	Year of death	Age at death	Details	Previous health
Father								
Mother								
Siblings (No. 1)								
(No. 2)								
(No. 3)								
(No. 4)								
(No. 5)								
(No. 6)								

PAST HISTORY

Please give dates if you have had any of the following and state whether severe (s), moderate (m), or light (l).

Allergic Reactions _____
Amoebic Dysentery _____
Anemia _____
Asthma _____
Cancer _____
H.I.V. _____
Diabetes _____
Tuberculosis _____
Rheumatic Heart Disease _____
Epilepsy _____
D.V.T./Blood Clots/Embolism _____
Venereal Disease _____

Hemorrhoids (Piles) _____
Jaundice _____
Kidney Stones _____
Typhoid _____
Malaria _____
Pneumonia _____
Whooping Cough _____
Arthritis _____
Serious illness of any kind _____
Serious injuries _____
Disabilities _____
Peptic Ulcer _____

Please indicate with a check mark if you have ever been advised to have any of the following tests (other than at the time of a routine physical):

Heart tests ___ Blood tests ___ Specialist consultation ___ Operations ___ Spinal fluid examination ___
X-ray examination or x-ray treatments ____ CT scans or MRI exams ____

Have you ever been rendered unconscious because of a blow on the head? ____ Been overcome by heat? _____

Had a nervous breakdown? ____ Had sunstroke? ____ Had frostbite? _____ Had chemical poisoning? ____

Are you now or have you been treated by any physician, osteopath or chiropractor within the past two years? _____

If so, for what? _____

When was your last chest x-ray? Date _____ Result _____ Tuberculin test? Date _____ Result _____

List immunizations you have had with the date _____

_____

Have you any physical, emotional or mental disability? _____

Have you ever consulted a psychologist, psychiatrist and/or other counselor? Yes ____ No _____ If yes, please explain

_____

_____

Since age 17, have you had a homosexual experience? _____ If yes, please explain _____

SYSTEMIC REVIEW

Please answer the following yes or no questions. At the end of each section indicate onset, frequency, severity, treatment and other pertinent details. Answer every question.

HEAD AND NERVOUS SYSTEM

Have you ever been subject to headaches/faintness/dizziness/blackouts/convulsions? _____
Do you have any phobias (fears)? _____ Do you have obsessions/compulsions? _____
Do you have any difficulty with vision/hearing/noises in the ear? _____
Are there times when you have trembling/shakiness/sweating/stammering/hysteria/chills/trouble sleeping? _____
Have you ever had frequent colds/sinus trouble/running ears/earache/unusual fatigue? _____
Do you have difficulty with poor appetite/overeating/bad or frightening dreams? _____
Have you had a stroke? _____ Do you ever feel depressed? _____
Have you ever felt suicidal? _____ Do you have a way to handle stress? _____
Details:

MUSCULO-SKELETAL

Have you ever been bothered by weak or painful feet/cold hands and feet even warm weather/frequent backaches? _____
Have you ever had any twitching of the head, hands or shoulders/paralysis/neuritis/arthritis/numbness or tingling of a part of your body? _____
Have you ever had injury to bone/joint/muscle/knee cartilage/head/severe sports injury/motor vehicle accident? _____
Do you have a joint problem or weakness of any muscle? _____
Details:

HEART AND LUNGS

Have you been subject to a cough lasting more than one month/spitting up blood/swelling of ankles/high blood pressure/heart murmur? _____
Are you now or have you been subject to shortness of breath/wheezing/palpitations/thumping of heart/pain in chest/heaviness in chest? _____ Have you had a heart attack? _____
Details:

DIGESTIVE SYSTEM

Have you ever been subject to vomiting blood, passing blood from rectum, black bowel movements, hemorrhoids, hernia? __
Other than symptoms related to influenza, have you ever had attacks of gassiness, indigestion, stomach pain, diarrhea, constipation, colitis, abdominal cramps, nausea, vomiting? _____
Have you had a problem with bulimia, anorexia or compulsive overeating? _____
Details:

GENITO-URINARY

Do you have a problem with wetting the bed, starting or stopping urination? _____
Have you ever had burning urination, getting up at night to urinate, blood in the urine, discharge from the bladder or genitalia, bladder, prostate, fallopian tube, kidney infection? _____
Details:

GENERAL

What over-the-counter or prescription drugs do you use? _____
Describe your use of caffeine, tobacco, alcohol, illegal drugs of any kind: _____
Are you subject to unpredictable wide swings of mood? _____
Have you been absent from work due to illness in the past five years or from normal activity in case you are not employed?
Yes _____ No _____ If this has already been covered, refer to the question where you answered it. If not, give detail:
_____
Have you ever received workman's compensation or disability payments? Yes ____ No ____ When? _____
For how long? _____ For what? _____

MENSTRUAL HISTORY

Age at onset _____ Interval between periods _____ Duration of period _____ days.
Regular or irregular? _____ Date of last period _____ Describe current contraceptive use _____
Amount – scant, moderate, profuse _____ Is PMS a problem? _____
Are you bothered before menstruation by depression or irritability? _____
Discomfort: none, slight, moderate, severe: _____
Does your menstruation interfere with physical/social activities? Yes _____ No _____
Are you subject to any bleeding or discharge between periods? Yes _____ No _____
Have you had any C-sections, miscarriages, normal deliveries? Give dates, any complications _____
_____

I certify that I have answered the above questions fully and honestly and that there are no other significant health facts known to me.

Signed _____ Date _____