



## Health and Medical History Questionnaire

COMPLETION OF THIS FORM IS ENTIRELY VOLUNTARY, but is encouraged for the safety of the students involved with GeoJourney. The questionnaire will be kept confidential and will be reviewed only by the GeoJourney Director and Associate Director. The information provided will be given to others (medical personnel, staff, etc.) only in an emergency situation, or when deemed necessary by the Director/Medical-Person-in-Charge for the student's safety in the field. This form is for your protection; the more complete the form, the better the medical treatment you may receive, if needed. **IMPORTANT:** If you know or suspect that you have some medical situation that may be aggravated by intense field work and the situation is not covered in any of the questions in this form, you should explain it in section 9, at the end of this form. Also, if you discover at any point before or during the trip that you need to amend this application (i.e. discover you have the hepatitis-B virus), you should do so as soon as reasonably possible.

Please print legibly or type.

Name: \_\_\_\_\_ Sex: male female (please circle one)

Social Security #: \_\_\_\_\_ BGSU ID#: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Health Insurance Company that you are covered under: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insurance Company's Phone Number: \_\_\_\_\_

### Contact Persons

Name of personal physician (or HMO): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

List two individuals below who could be notified in case of an emergency (i.e. parents, spouse, sibling, close family friend, etc.).

1. Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_

2. Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_

## 1. Family Medical History

Check the appropriate space for any serious illness you are aware of that has occurred in a blood relative (grandparents, parents, brothers, sisters, children, etc.):

anemia  high blood pressure  thyroid disorders  
 ulcers  bleeding tendency  migraine headaches  
 cancer  rheumatoid arthritis  heart problems  
 HIV positive  tuberculosis  diabetes  
 stroke  allergies (insects, pollen, medicines, etc.)  other (explain)

Explain any checked item above and add anything not listed:

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## 2. Personal Medical History

Please check the appropriate space for any illness that you have had in the past or have now:

anemia, sickle cell  anemia, other  meningitis  
 gout  mononucleosis  headaches, migraines  
 asthma  phlebitis  bleeding tendencies  
 eating disorders  pneumonia  bronchitis  
 heart disorders  rheumatic fever  cancer  
 hepatitis  HIV positive  colitis  
 hypoglycemia  hyperglycemia  stroke  
 diabetes  high blood fats  thyroid disorders  
 intestinal parasites  tuberculosis  frequent ear infections  
 kidney stones  ulcers  breast fibrocystis  
 malaria  rheumatoid arthritis  gallbladder disorders  
 depression

Explain any check above and add any situation is not listed:

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### 3. General allergens

Please check any of the following to which you have had an allergic reaction:

insect bites or stings  animal hair/dander

pollen (hay fever)  foods (specify below)

other (specify below)

If you checked any box above, do you carry an epipen with you at all times? (circle one)

Yes No

If you do NOT carry an EpiPen®, you should seriously consider obtaining one (or a similar product) if your allergies are severe and/or you have a family history of allergies that you may not know if you have. [http://www.allergic-reactions.com/epipen\\_main.html](http://www.allergic-reactions.com/epipen_main.html)

Explain any checks above here:

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### 4. Medicinal Allergens

Please check the appropriate space for any drug to which you know or suspect you are allergic:

penicillin  pain medicine (i.e. codeine, morphine, etc.)

ampicillin  Demerol

sulfa drugs  Novocain or other local anesthetic

tetracycline  tranquilizers (i.e. Librium, Valium, etc.)

aspirin  erythromycin or other "mycins"

X-ray dyes  sleeping pills (i.e. Seconol, Nembutal, etc.)

vaccine sera  others (specify below)

Explain any of the checks above and detail any symptoms you typically have:

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## 5. Medications

Please check the appropriate space for any drugs that you are currently using or use regularly:

- \_\_\_\_\_ amphetamines \_\_\_\_\_ cough medicine \_\_\_\_\_ diet pills
- \_\_\_\_\_ antacids \_\_\_\_\_ muscle relaxants \_\_\_\_\_ menstrual cramp medicine
- \_\_\_\_\_ antihistamines \_\_\_\_\_ diuretic \_\_\_\_\_ nasal spray
- \_\_\_\_\_ allergy shots \_\_\_\_\_ ear drops \_\_\_\_\_ Ritalin
- \_\_\_\_\_ antibiotics \_\_\_\_\_ eye drops \_\_\_\_\_ pain medication
- \_\_\_\_\_ antidepressants \_\_\_\_\_ epilepsy medication \_\_\_\_\_ sleeping pills
- \_\_\_\_\_ aspirin \_\_\_\_\_ headache medication \_\_\_\_\_ thyroid medication
- \_\_\_\_\_ asthma medication \_\_\_\_\_ heart medication \_\_\_\_\_ skin medication
- \_\_\_\_\_ barbiturates \_\_\_\_\_ hormones \_\_\_\_\_ tranquilizers/sedatives
- \_\_\_\_\_ birth control pills \_\_\_\_\_ insulin \_\_\_\_\_ vitamins (specify below)
- \_\_\_\_\_ blood pressure medication \_\_\_\_\_ iron supplements \_\_\_\_\_ laxatives
- \_\_\_\_\_ cortisone \_\_\_\_\_ other (specify below)

Explain any check above and add anything not listed:

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## 6. Immunizations and Tests

Please give the most recent year you were immunized or tested for the conditions below. If it was more than 10 years ago, you can just indicate "childhood". If you are not sure, check the dates with your doctor, or have the procedure done again.

- \_\_\_\_\_ DTP (usually given at infancy)
- \_\_\_\_\_ Measles/mumps/rubella
- \_\_\_\_\_ Polio
- \_\_\_\_\_ Tetanus or tetanus/diphtheria
- \_\_\_\_\_ Tuberculin skin test (result was: \_\_\_\_\_ positive \_\_\_\_\_ negative)
- \_\_\_\_\_ Chest X-ray (if skin test was positive)
- (result was: \_\_\_\_\_ positive \_\_\_\_\_ negative)

If positive, describe treatment: \_\_\_\_\_

**7. Miscellaneous Health Issues**

Do you have any illness (including depression) or injury that requires you to consult a physician or other health care professional on a periodic basis? \_\_\_\_ yes \_\_\_\_ no (If yes, explain below.)

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Please complete the following statements:

1. You wear: \_\_\_\_ glasses \_\_\_\_ contact lenses \_\_\_\_ none.

If you wear either glasses or contacts, can you:

pass a driving test without them? \_\_\_\_ read comfortably without them? \_\_\_\_ see anything without them? \_\_\_\_

2. You tend to experience:

carsickness: \_\_\_\_ yes \_\_\_\_ no \_\_\_\_ don't know

poor night vision: \_\_\_\_ yes \_\_\_\_ no \_\_\_\_ don't know

seasickness: \_\_\_\_ yes \_\_\_\_ no \_\_\_\_ don't know

dizziness due to heights: \_\_\_\_ yes \_\_\_\_ no \_\_\_\_ don't know

**8. Diet**

Are you on a restricted diet for any medical reason? \_\_\_\_ yes \_\_\_\_ no

If yes, explain: \_\_\_\_\_

Do you prefer to avoid animal products in you diet? \_\_\_\_ yes \_\_\_\_ no

I don't eat the following; \_\_\_\_ red meat \_\_\_\_ fish, seafood \_\_\_\_ poultry \_\_\_\_ eggs \_\_\_\_ dairy products

***GeoJourney will not accommodate Vegans. There must be one of the above in your diet providing protein.***

Do you regularly drink beverages containing caffeine?

\_\_\_\_ no

\_\_\_\_ yes, usually drink the following;

\_\_\_\_ coffee \_\_\_\_ tea \_\_\_\_ cocoa \_\_\_\_ colas \_\_\_\_ other I usually drink \_\_\_\_ cups/glasses/cans a day, on average.

**9. General**

Is there ANYTHING in your medical history or present health status that has not been covered in this form, and which you think we should be aware of in order to facilitate your safe participation in GeoJourney? Please explain fully, and attach additional pages if necessary.

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