P.O. Box 266
Pine Forge, PA 19548
Phone: 610-326-4610 ext. 347
Phone: 800-830-0224 ext. 347
Fax: 610-326-3946
Email: prodgers@aecsda.com
Website: fit4youretreat.org

MEDICAL ASSESSMENT FORM

Please Print Clearly

Allergies: _____

DOB: _____

First Name _____

Last Name _____

PERSONAL INFORMATION

Last Name _____First Name _____ MI_____

Date of birth _____ Age ___ Male ❑ Female ❑ Marital Status _____ Nationality (optional) _____

Address _____

City _____ State_____ Zip Code _____

Day Phone _____ Cell Phone _____ Evening Phone _____

Current Profession _____ Religious Affiliation (optional) _____

Emergency Contact _____ Relationship _____ Phone _____

Last Date of Physical Examination _____ Do you have health insurance? Yes ❑ No ❑

ATTACH A PHOTOCOPY OF BOTH SIDES OF INUSRANCE CARD

What are your health goals for the next year? _____

MEDICAL BACKGROUND

Do you have now (current) or have you had (past) any of the following conditions?

Condition	Current	Past	Family History
Abnormal Heart Rhythms			
Alcohol/Drug abuse			
Allergy (hay fever)			
Anemia			
Angina			
Anxiety			
Arthritis: ❑Rheumatoid ❑Osteoarthritis			
Asthma			
Bladder/Kidney Problems			
Blood Cot: ❑Leg ❑Lung			
Blood Transfusion			
Breast Lump (benign)			
Cancer: ❑Breast ❑Colon ❑Ovarian ❑Prostate ❑Other _____			
Cardiac Bypass Surgery			
Cataracts			
Chicken Pox			
Colon Polyp			
Congestive Heart Failure			
Coronary Artery Disease			
Depression			
Diabetes: ❑Adult onset ❑Childhood onset			
Diverticulosis			
Emphysema			

Condition	Current	Past	Family History
Fractures (broken bones)			
Gallbladder Disease			
Gastroesphageal Reflux (heartburn/GERD)			
Glaucoma			
Gout			
Heart Attack			
Hepatitis: ❑Type A ❑Type B ❑Type C ❑Other _____			
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Hyperglycemia			
Hypoglycemia			
Internal Cardiac Defibrillator			
Irritable Bowel Syndrome			
Kidney Disease/Failure			
Kidney Stones			
Liver Disease			
Low Blood Pressure			
Lupus			
Migraine Headaches			
Osteoporosis			
Overweight			
Pacemaker			
Pancreatic Disease			
Peripheral Vascular Disease			
Pneumonia			
Prostate: ❑Enlargement ❑Nodules			
Respiratory			
Seizure/Epilepsy: Date of last seizure_____			
Sickle Cell Anemia			
Skin Condition: ❑Eczema ❑Psoriasis ❑Abnormal Moles			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid: ❑Nodule ❑Overactive/Hyperthyroidism ❑Underactive/Hypothyroidism			
Underweight			
Vertigo			
Other _____			
Other _____			

OTHER HEALTH ISSUES:

Tobacco Use: Smoke cigarettes: ❑Never ❑No. If no, Quit Date _____ ❑Yes
How many years did you smoke? _____ Approximately how many packs a day did you smoke? _____
Current smoker: Packs/day: _____ # of years: _____
Other tobacco: ❑Pipe ❑Cigar ❑Snuff ❑Chew

Alcohol Use: Do you drink alcohol? ❑No ❑Yes If yes, # of drinks/week: _____ ❑Beer ❑Wine ❑Liquor

Exercise: Do you exercise regularly? ❑ No ❑ Yes How Often? _____

What Kind of Exercise? _____ How Long (minutes)? _____

Diet: How would you rate your diet? ❑Good ❑ Fair ❑Poor

Are you able to walk without assistance? ❑Yes ❑ No if no, do you require assistance from ❑Cane ❑Walker ❑Crutches

MEDICATIONS

List all prescriptions, over-the-counter medications, vitamins and herbal supplements that you are currently taking. Inhalers and Epipen information must be included, even if they are for occasional or emergency use only. Attach a separate sheet if more space is needed.

Medication Name	Prescribing Doctor's Name	Reason for taking the medication	Dose (such as 2 mg, 1 tsp)	How often? (such as 3x/day)

Please list all allergies below: (including medication, food, plants or insect bites)

Allergic to	Describe Reaction

Do you have any medical conditions requiring any special attention? If so, please describe below:

_____

_____

_____

RELEASE STATEMENT

I, hereby, authorize the staff of the FIT 4 YOU Retreat organization, under the auspices of the Allegheny East Conference Corporation of Seventh-day Adventists, in case of an emergency, real or supposed, to secure treatment for myself, including, but not limited to, surgery, medication, x-ray and examinations. By signing below, I indicate that I understand that I am fully responsible for all medical expenses incurred on my behalf.

All completed forms are confidential and will be kept in a secure location in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Print Name _____

Signature _____ Date _____

PLEASE SUBMIT ALL COMPLETED FORMS BY JUNE 9TH, 2017