Medical History

Dates of Your Trip:		Airline, Flight #	
Name of Your Church or Group		Team Leader	
Full Name (on passport)			
Passport #		Preferred Name	
Mailing Address			
Home Phone		Cell Phone	
Email address			
Date of birth		Height/Weight	
Age		Blood Type & Rh (if known)	
Allergies (Food, drug, Environmental Allergens)			

Do you have a history of:			
High BP	Asthma	Migraines	Heart Disease
Cancer	Depression	Diabetes	Epilepsy/Seizures
Other:			
Do you have:			
Hearing deficit:	Use hearing aid:	Vision deficit?	Wear glasses or contacts:
Date of last visit to physician:		Date of last dental visit:	
Please list ALL medicines you currently take including over the counter:			
What is your appraisal of your current health status? (Excellent, Good, Fair, Poor)			
What level of activity are you able to participate in? (Vigorous, Moderate, Minimal)			
Beneficiaries for travel Insurance 1. Relationship: 2. Relationship:			