Personal Health Review

Name _____

This is in part to help you assess your own level of health, but also to provide us with information on your health. If you have had or are currently experiencing any of the following conditions: 1) Check with your physician about your fitness to undertake a physically active trip; and 2) Circle the numbers and give details in the blank space. Be specific, include: dates, names of medication, history of condition, current status, etc.. Use additional paper if necessary.

1. Problems with vision or hearing -- requiring glasses, contact lenses or hearing aid.
2. Dizzy spells, fainting, convulsions, persistent headaches.
3. Frequent infection of throat, tonsils, sinuses, ear.
4. Chronic cough, bronchitis, bloody sputum.
5. Shortness of breath, or asthma on exertion.
6. Chest pains on exertion or deep breathing.
7. Palpitation of the heart, irregular heart beat, heart murmurs, or poor circulation.
8. Low or high blood pressure.
9. Frequent nausea or vomiting, food intolerance's, heartburn.
10. Jaundice or hepatitis.
11. Frequent diarrhea or blood in the stools.
12. Frequent abdominal cramps, severe menstrual cramps.
13. Hernia, lifting restrictions.
14. Difficulty urination, burning or pain on urination, frequency in urinating.
15. Kidney infection or stones.
16. Chronic pain in neck, back, shoulders, arms or legs.
17. Broken bones, joint dislocation, serious sprains, weakness of muscles.
18. Joint pains, swelling or stiffness without injury.
19. Any severe injury to head, chest, internal organs.
20. Severe illness requiring hospitalization or prolonged incapacitation.
21. Chronic skin problems (rash infection).
22. Reaction to extremes of temperature, heat exhaustion, sunstroke, frostbite, impaired circulation.
23. Claustrophobia, agoraphobia, acrophobia (strong fear of confined places, open areas, or heights.)
24. Abuse of alcohol, drugs, or medicines.
25. Episodes of depression, anxiety, hysteria, nervousness.
26. History of diabetes, thyroid trouble, bleeding problems.
27. Hypoglycemia.
28. Had or presently have a drug-related problem?
29. Are you under treatment of a psychologist or psychiatrist?
30. Currently on any medication. If so, what? _____
31. Allergic to any: Food(s) _____ Drug(s) _____ Other _____
32. Special dietary restrictions (i.e. vegetarian, macrobiotic, etc.)
33. Any medical conditions, allergies, sun sensitivity or dietary restrictions which might cause difficulties or need special attention during the trip:

MEDICAL INSURANCE COVERAGE: Company: _____ Address: _____

Policy or certificate number: #_____

Does it provide world-wide, 24-hour coverage: Yes__ No__