

**New Life Advance International
PO Box 35857
Houston, TX 77235-5857**

HEALTH QUESTIONNAIRE

Note: All responses are confidential. If deemed appropriate, and only upon receipt of your written authorization, your health information will be referred to licensed physicians and/or mental health professionals for further evaluation.

Name: _____
Last
First
Middle

Date: _____ Marital Status: S M W D Sex: _____ Age: _____

Present Address: _____
Street
City
State
Zip

Birth Place: _____ DOB: _____ Date of Marriage: _____

When contemplating appointment? _____ Country of Service: _____
 City: _____ Type of Ministry: _____

Have you served previously with NLAI? _____ When? _____ Where? _____

FAMILY HISTORY

Person	Sex M/F	Age	Indicate Living or Deceased If living indicate health status	Age at Death	Year of Death	Previous Health	Cause of Death
Father							
Mother							
Sibling 1							
Sibling 2							
Sibling 3							
Sibling 4							
Sibling 5							
Spouse							
Child 1							
Child 2							
Child 3							
Child 4							
Child 5							

Hereditary of Family Diseases

Mark X after any that pertains to your immediate family: father, mother, grandparents, uncles or first cousins. Give further details below.

- | | | |
|--------------------|----------------------------|-------------------------------------|
| 1. Cancer _____ | 6. Obesity _____ | Recurring headaches: _____ |
| 2. Goiter _____ | 7. Kidney disease _____ | 12. Convulsions _____ |
| 3. Athsma _____ | 8. Tuberculosis _____ | 13. Heart/circulatory disease _____ |
| 4. Allergies _____ | 9. Nervous Breakdown _____ | |
| 5. Diabetes _____ | 10. Mental disorders _____ | |

INFECTIOUS DISEASES: Give year of illness if possible.

- | | | |
|-------------------------|----------------------|--------------------------------|
| 1. Chicken Pox _____ | 7. Influenza _____ | 13. Rheumatic Fever _____ |
| 2. Measles _____ | 8. Pleurisy _____ | 14. Typhoid Fever _____ |
| 3. German Measles _____ | 9. Dysentery _____ | 15. Tuberculosis _____ |
| 4. Mumps _____ | 10. Pneumonia _____ | 16. Poliomyelitis _____ |
| 5. Scarlet Fever _____ | 11. Malaria _____ | 17. Hepatitis _____ Type _____ |
| 6. Tonsillitis _____ | 12. Diphtheria _____ | 18. Other _____ |

OTHER ILLNESSES

GENERAL HEALTH INFORMATION (For Yes answer, give details e.g. dates, seriousness, etc.)

	Yes	No	Details Regarding General Health Condition
Item			
Ever applied for disability			
Any known health disability			
Denied health insurance			
Unable to hold a job due to allergies			
Inability to assume certain body positions			
Other medical conditions			
Worked with radioactive materials			
Refused employment due to health			
Do you follow a systematic fitness program?			

HEALTH HABITS

	Yes	No	Details Regarding Your Health Habits
Do you take medication regularly?			
Have you ever followed a special diet?			
Do you fall asleep quickly?			
Do you use sedatives to sleep?			
Have you used tobacco in the past 5 years?			
Do you drink alcoholic beverages?			
Have you used illegal substances?			

REVIEW OF SYSTEMS

EYES:

	Yes	No	Details Regarding Your Body Systems
Injury to eyes			
Visual trouble			
Blurred vision			
Glasses worn (how long)			
Conjunctivitis (pink eye)			
Aching Eyes			
Surgery on eyes			
Blindness (either eye)			

EARS:

	Yes	No	Details Regarding Your Body Systems
Hearing problems/deafness			
Earaches			
Discharge from ears			
Ruptured ear drum			

NOSE, SINUSES AND THROAT:

	Yes	No	Details Regarding Your Body Systems
Nasal Discharge			
Nosebleed			
Surgery on nose			
Sinusitis			
Repeated sore throats			
Tonsillectomy			
Repeated hoarseness			

GUMS AND TEETH:

	Yes	No	Details Regarding Your Body Systems
Bleeding gums			
Severe tooth trouble			
Extraction of teeth			
Fillings			
Dental visit past 6 months			
Plates, bridges, dentures			
Bleeding after extraction			
Pyorrhea			

RESPIRATORY SYSTEM:

	Yes	No	Details Regarding Your Body Systems
Frequent colds			
Chronic cough			
Coughing up blood			
Coughing up pus			
History of Tuberculosis (self)			
Exposure to Tuberculosis			

	Yes	No	Details Regarding Your Body Systems
Asthma			
Other lung disease			

CARDIO-VASCULAR SYSTEM:

	Yes	No	Details Regarding Your Body Systems
Known heart trouble			
Heart Murmur			
Pressure or pain over heart			
Abnormal Electrocardiogram			
High blood pressure			
Low blood pressure			
Shortness of breath			
Swelling ankles			
Varicose veins			
Thrombo phlebitis			
Chilblains			
Anemia			
High cholesterol			
Other blood disease			

URINARY SYSTEM:

	Yes	No	Details Regarding Your Body Systems
Frequent urination			
Painful urination			
Difficulty in urination			
Kidney stones			
Blood in urine			
Pus in urine			
Albumin in urine			
Sugar in urine			
Kidney trouble			
Bladder trouble			

BONES AND JOINTS:

	Yes	No	Details Regarding Your Body Systems
Arthritis			
Painful or swollen joints			
Bone deformity			
Fractured bones			
Lameness			
Loss of limb, toes, fingers			
Dislocated joints			
Locked or "trick" knee			
Brace or back support			
Herniated disc			
Other			

MUSCLES:

	Yes	No	Details Regarding Your Body Systems

	Yes	No	Details Regarding Your Body Systems
Low back pain, etc.			
Muscle stiffness			
"Whip lash" injury			
Painful feet or legs			

SKIN:

	Yes	No	Details Regarding Your Body Systems
Sensitive skin			
Recurrent Boils			
Severe itching			
Skin rash			
Hives			
Excessive sweating			
Oily or dry skin			
Poison ivy or oak			
Moles removed			
Pilonidal cyst			
Reaction to penicillin/other drugs			
Food allergies			
Hay fever			
Other allergies			
Skin test for allergies			
Sensitivity to heat or cold			
Precancerous skin			
Skin cancer			

METABOLISM:

	Yes	No	Details Regarding Your Body Systems
Thyroid disease			
Take/have taken Thyroid meds			
Surgery on thyroid			
History of diabetes (self)			
Excessive thirst			
Frequent urination day or night			
Excessive appetite			
Fatigue or weakness			
Night sweats usually			
Difficulty in keeping warm			
Rapid weight loss or gain			

DIGESTIVE SYSTEM:

	Yes	No	Details Regarding Your Body Systems
Difficulty swallowing			
Frequent indigestion			
Heartburn			
Nausea or vomiting			
Frequent belching			
History of stomach ulcers			
Appendicitis			
Appendectomy			

	Yes	No	Details Regarding Your Body Systems
Hemorrhoids or rectal trouble			
Rectal bleeding			
Black stools			
Light colored stools			
Frequent diarrhea			
Constipation			
Use of laxatives			
Blood and mucus in stools			
Foamy stools			
Hepatitis			
Gall stones			
Gall bladder trouble			
Jaundice			
Frequent use of meds for indigestion			
Disease of the bowels			

NERVOUS SYSTEM:

	Yes	No	Details Regarding Your Body Systems
Head injury & loss of consciousness			
Paralysis of any kind			
Double vision or spotty vision			
Fainting			
Dizziness			
Epilepsy, seizures			
Difficulty with coordination			
Severe headaches			
Headaches-frontal type			
Headaches-back of head			
Headaches-side of head			
Headaches with vomiting or nausea			
What medications for headaches?			
Stammering or speech difficulty			
Neuritis			
Temporary blindness			
Numbness or tingling of body			

EMOTIONAL SYSTEM:

	Yes	No	Details Regarding Your Body Systems
Feelings of discouragement			
Unable to sleep in early am hours			
Difficulty sleeping			
Sleep walking			
Excessive worry			
Boredom			
Frequent nightmares			
Feelings of suicide			
Attempted suicide			
Hard to make friends			
Suspicious in nature			
Morning fatigue			
Received therapy from licensed counselor?			

	Yes	No	Details Regarding Your Body Systems
Were you ever admitted to a mental Hospital?			
Received shock treatment			
Taken meds for depression or other mental disorders?			
Taken sedatives			
Taken narcotics			
Tendency to bite nails			
Easily fatigued at work			
Diarrhea under stress and pressure			
Twitching of face muscles			
Easily scared			
Uneasy in crowds			
Uneasy in high places			
Loss of memory			
Problem of bedwetting after age 4			
Emotional illness			
Homosexual tendencies			
Masturbation problems			
Other sex or marital problems			

MISCELLANEOUS:

	Yes	No	Details Regarding Your Body Systems
Tumor, growth, cysts?			
Cancer of any kind			
Advised to have surgery but have not done			
Hernia			
Any other surgery			
Hospitalization other than for surgery of delivery of baby			
Circumcision			
Other injury, illness not noted			
Consulted physicians or other health Practitioners within the last 5 years			

PREVIOUS EXAMS:

Have you had X-rays of the following:

X-rays	Yes	No	Details Regarding Your Body Systems
Chest (date)			
Stomach (date)			
Bowel (date)			
Others (date)			

GENERAL HEALTH DATA:

Estimate of present health (circle one): Vigorous Good Fair Poor

Height: _____ Weight: _____

Maximum weight: _____ When (yr): _____

Recent weight changes: Plus _____ Minus: _____

Recent blood pressure (if known): _____

Blood Type: _____ Rh: _____

Scars or other marks on body: _____
 Time loss from school or work in the past 5 years due to illness: _____
 How many cups of coffee do you drink per day? _____
 How many hours do you sleep a night (average)? _____
 Do you take regular exercise? _____
 What hobbies do you have? _____

WOMEN ONLY:

Age onset of menstruation: _____
 Interval between periods: _____
 Duration of periods: _____
 Quantity of flow (No. pads per day): _____
 Number of pregnancies: _____
 Number of miscarriages, stillbirths or abortions (give dates): _____
 Number of normal deliveries (give dates): _____
 If pregnant, give expected date of delivery: _____

	Yes	No	Details of Female Health Issues
Vaginal Discharge			
Surgery of female organs			
Cesarean section			
Excessive pain at menstruation			
Irregular menstruation			
Absenteeism from work or school due to menstrual pain			
Known to have endometriosis			
Taken meds for menstrual pain			
Taking birth control pills			
Use other birth control methods (specify)			
Taking hormones other than thyroid			

Signature of Applicant: _____ Date: _____

 (Do not write below this line)

Recommendation by Medical Consultant: