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| HEALTH HISTORY QUESTIONNAIRE | | | | | | | | | | | | | | | | | | |
| **All questions contained in this questionnaire are strictly confidential  and will become part of your volunteer medical record.** | | | | | | | | | | | | | | | | | | |
| Name (Last, First, M.I.): | | |  | | | | | 🞎 M 🞎 F | | DOB: | |  | | | | | | |
| Marital status: | | 🞎 Single 🞎 Partnered 🞎 Married 🞎 Separated 🞎 Divorced 🞎 Widowed | | | | | | | | | | | | | | | | |
| Previous or referring doctor: | | | | |  | | Date of last physical exam: | | | | | | |  | | | | |
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| PERSONAL HEALTH HISTORY | | | | | | | | | | | | | | | | | | |
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| Have you had any of the following childhood illnesses? | | | 🞎 Measles 🞎 Mumps 🞎 Rubella 🞎 Chickenpox 🞎 Rheumatic Fever 🞎 Polio | | | | | | | | | | | | | | | |
| Immunizations and dates: | | | | 🞎 Tetanus | |  | 🞎 Yellow Fever | | | |  | | | | | | | |
| 🞎 Hepatitis | |  | 🞎 Chickenpox | | | |  | | | | | | | |
| 🞎 Influenza | |  | 🞎 MMR Measles, Mumps, Rubella | | | | | |  | | | | | |
| List any medical problems that other doctors have diagnosed: | | | | | | | | | | | | | | | | | | |
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| Surgeries: | | | | | | | | | | | | | | | | | | |
| Year | Reason | | | | | | | | Hospital | | | | | | | | | |
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| Other hospitalizations: | | | | | | | | | | | | | | | | | | |
| Year | Reason | | | | | | | | Hospital | | | | | | | | | |
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| Have you ever had a blood transfusion? | | | | | | | | | | | | | | | 🞎 | Yes | 🞎 | No |
| Please turn to next page | | | | | | | | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers: | | | | | | | | | |
| Name the Drug | | Strength | Frequency Taken | | | | | | |
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| Allergies to medications: | | | | | | | | | |
| Name the Drug | | Reaction You Had | | | | | | | |
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| Diet/Food Allergies | | | | | | | | | |
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|  | Do you have any dietary restrictions? | | | 🞎 | | Yes | 🞎 | | No |
| If yes, what are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |  |
| Do you have any food allergies? | | | | 🞎 Yes | | | 🞎 No | |
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| Mental Health History | | | | | | | | |
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|  | Do you have a history of mental illness? | | | | 🞎 Yes | | | 🞎 No |  |
| If yes, which of the following mental illnesses have you received treatment for? | 🞎 Depression 🞎 Bipolar Disorder 🞎 Anxiety Disorder 🞎 OCD 🞎 Eating Disorder 🞎 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| Please list any medications you are currently taking: | | 🞎 |  | 🞎 | |  | | |
| 🞎 |  | 🞎 | |  | | |
| 🞎 |  | 🞎 | | |  | |
| Please note: If you have a prescription for anti-depressants/psychiatric drugs, you will need a statement from your mental health care provider that you are healthy and able to perform the work expected of you. Your safety and security is our number one priority! | | | | | | | | |

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| Social Health | | | |
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|  | Are you sexually active? | 🞎 Yes | 🞎 No |  |
| If yes, which type of birth control are you currently using? | 🞎 Condoms 🞎 IUD 🞎 The Pill 🞎 Implanon 🞎 Nuva Ring 🞎 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \*We ask this question because our organization works with at-risk populations in a high HIV prevalent community. Sexual health and safe-sex practices are important issues and we hold our volunteers to high standards as examples for the community. Some forms of birth control are harder to obtain here than others, so please discuss options with your doctor. | | |
| Members of the LGBTQIA community: Homosexuality is socially taboo in Tanzania and same-sex sexual acts are crimes punishable by the state. As an organization, we are welcoming to all gender identities and sexual orientations. However, because we work closely with socially conservative communities, we do our best to remain neutral, yet supportive to all. We ask our volunteers to maintain culturally appropriate public behavior. | | | |