

HEALTH QUESTIONNAIRE

FULL NAME (AS IT APPEARS ON PASSPORT): _____

FAMILY DOCTOR'S NAME: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE: _____

YOUR HEALTH: (CIRCLE ONE) EXCELLENT GOOD POOR

LIST ALL MEDICATIONS YOU USE. PROVIDE DOSAGE, FREQUENCY AND REASON FOR ALL MEDICATIONS:

MEDICATION/DOSAGE	FREQUENCY	REASON FOR USE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ANY ALLERGIES: MEDICINE, FOOD, CONTACT WITH SUBSTANCES, ANIMALS, ETC:

ALLERGY	REACTION	MEDICAL TREATMENT
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DATE OF YOUR MOST RECENT TETANUS SHOT: _____

ANYTHING ELSE WE SHOULD KNOW: _____

SIGNATURE

DATE

This form will remain private and will only be used for emergencies.
If you have questions or privacy concerns, email Medical@iServants.com

MAIL TO: INTERNATIONAL SERVANTS, PO BOX 350070, PALM COAST, FL 32135