Zambia Medical Mission Medical History Form
All information will be kept private. Please return form to:
Zambia Mission, 658 E.N. 21st St., Abilene, TX 79601

Name:_____ DOB:_____ Date Form Completed:_____

Allergies:

1. Known drug allergies? Please list:

   a._____ b. _____

   c. _____ d. _____

2. Known food allergies? Please list:

   a._____ b. _____

   c. _____ d. _____

3. Have you had an allergic reaction to any of the following:

   ____Eggs ____Quinilines (Chloroquine, Lariam)
   ____Sulfa Drugs ____Pyrimethamine
   ____Antibiotics ____Tetracycline (doxycycline)
   ____Chrysanthemums ____Insects
   ____Other: _____

Blood Type: _____

Immunizations/Vaccinations:

1. Were you born in the United States? Yes____ No____

2. Have you completed the following?

a.	Hepatitis A	Yes____	When_____	No____
b.	Hepatitis B	Yes____	When_____	No____
c.	Meningococcal	Yes____	When_____	No____
d.	MMR	Yes____	When_____	No____
e.	Polio Series	Yes____	When_____	No____
f.	Tetanus	Yes____	When_____	No____
g.	Typhoid	Yes____	When_____	No____
h.	Yellow Fever	Yes____	When_____	No____
i.	Diptheria	Yes____	When_____	No____
j.	Whooping Cough	Yes____	When_____	No____
k.	Shingles	Yes____	When_____	No____

   If "No", have you ever had measles, mumps, rubella or chicken pox? Yes____ No____
   If you have, please list

3. COVID Vaccination History:

   Manufacturer:_____ Date:_____ Lot #:_____
   Manufacturer:_____ Date:_____ Lot #:_____
   Manufacturer:_____ Date:_____ Lot #:_____
   Manufacturer:_____ Date:_____ Lot #:_____

Medical History:

1. Are you using steroids, receiving immunosuppressive therapy or chemotherapy?
   Yes____ No____

2. List **all** your current prescription medications and the medical condition treated:

	Current prescription medications	**Condition or reason for use**
a.	_____	_____
b.	_____	_____
c.	_____	_____
d.	_____	_____
e.	_____	_____

3. List all regularly used non-prescription medications (over the counter, vitamins, etc):

	Regularly used non-prescription medication	**Condition or reason for use**
a.	_____	_____
b.	_____	_____
c.	_____	_____

4. Have you been told you have any of the following conditions:

Yes	**No**	**Family History**		**Yes**	**No**	**Family History**	
____	____	____	Anemia	____	____	____	Hypertension
____	____	____	Asthma	____	____	____	High Cholesterol
____	____	____	Blood Clotting problems	____	____	____	Immune disorder
____	____	____	Cancer	____	____	____	Kidney disorder
____	____	____	Depression	____	____	____	Liver disease
____	____	____	Epilepsy	____	____	____	Lung disease
____	____	____	Ear infections (frequent)	____	____	____	Psychiatric
____	____	____	Eye problems	____	____	____	Psoriasis
____	____	____	Glaucoma	____	____	____	Sickle cell
____	____	____	G6PD deficiency	____	____	____	Stomach ulcer
____	____	____	Gout	____	____	____	Stroke
____	____	____	Hearing Loss	____	____	____	Thyroid disease
____	____	____	Heart disease	____	____	____	Other:_____

5. Surgeries:
   Please list any past surgeries and date (appendectomy, tonsillectomy, etc.)
   _____
   _____
   _____

   When was the last time you saw a doctor and what was it for? Date:_____
   _____
   _____