



Medical Form

To be completed by the applicant. Please type or print clearly.
Medical History (include dates)

- | | |
|---|---|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Poliomyelitis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Endocrine Disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Psychological Difficulties | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Speech Problem |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Other |

Do you use crutches, a wheelchair, artificial limb, or hearing aid?
Please specify _____

Do you ever modify your activities because of health or disability? Please explain. _____

Accidents:
Did you ever have any serious accidents? _____
Nature of injury: _____
Were you hospitalized? _____ Dates _____ What effects of the accident(s) persist? _____

Surgical History:
List operations and dates: _____
Psychiatric History:
Do you have any history of emotional difficulties? _____
Have you ever been under psychiatric care? _____
Hospitalized? _____ Dates _____ Are you currently under psychiatric care? _____

Date _____ Applicant's Signature _____

Personal Doctor

Name _____ Phone # _____

Address _____

City	State	Zip
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Are there any special medical conditions that might affect your service? (Specify any disabilities, chronic illness, special medications, allergies, restrictions, etc.)

Do you have an insurance policy which will cover you during your time of service, rather than the one provided while you are with the GSV?

If yes, name of the policy _____ Policy # _____

Please indicate any counseling or psychotherapy you have received and its impact on your life. Use a separate sheet of paper. Also, please ask your therapist to write a recommendation for you.

Therapist: _____ Phone #: _____

Address _____

City State Zip

Date _____ Applicant's Signature _____



Physical Examination Report

To be completed by physician. Please type or print.

Name of Applicant_____

Height_____ Weight _____ Overweight_____ Underweight_____

Remarks_____

General Appearance_____

Scars, deformities of body, etc._____

Hearing_____ Hearing aid necessary?_____

Vision: Right_____ Left_____ With correction: Right_____ Left_____

Mouth: Teeth_____ Date of last dental examination_____

Urinalysis_____

DT Booster (within 5 years) Date given_____

Tuberculin Skin Test within six months of date of this exam (circle test done)

Tine Test, PPD, Mantoux, Other _____

Results_____ Date_____

Circle any abnormality:

Eyes Ears Nose Throat Sinuses Thyroid Chest Breasts Heart Lungs

Abdomen Lymph Nodes Reflexes Back

Explanatory Remarks:_____

Any allergies, dietary restrictions?_____

Indicate any medications taken including recurrent non-prescriptive:_____

Any significant past medical problems?_____

Disabilities?_____

Any present medical problems? _____

Disabilities? _____

Explain any history of alcohol or drug abuse: _____

Mental Health (include history of psychological difficulties, treatment and recommendations.) _____

Are there any reasons why this person could not participate in the work of the Good Shepherd Volunteers or would have to modify his/her activities?

Are you the applicant's regular physician? _____

For how long? _____

Signature _____

(Please use name stamp or include RX with your signature).

Address _____

City State Zip Telephone _____

E-Mail _____

Please return this form directly to:

**Good Shepherd Volunteers
25-30 21st Ave.
Astoria, NY 11105**

FAX # (718) 777-1928