

CONFIDENTIAL MEDICAL QUESTIONNAIRE

In order to acquaint our staff with your medical needs, we require that you complete this Confidential Medical Record. If you become ill or are injured on the weekend we may share this information with medical personnel. Otherwise, **all information will be kept strictly confidential.** Please complete every item in every section. Mark N/A if any section is not applicable. If you are mailing this form to us, please keep a photocopy.

General Information:

Name: _____

Address: _____

City, State Zip: _____

Primary Phone: _____

Alternate Phone: _____

Date of Birth: _____

Age: _____

Height: _____

Weight: _____

Emergency Contact: _____

Relationship: _____

Primary Phone: _____

Alternate Phone: _____

Address: _____

Physician: _____

Physician Phone: _____

Insurance Company: _____

Policy Number: _____ exp. date: _____

1. Do you have any medical or physical conditions that would affect your participation in the Rites of Passage Adventure Weekend (ROPA)?

2. Do you need any medication during the weekend? If so, please insure that our on-site medical personnel have a list of medications you will have on Thursday.

3. Do you have any emotional or psychological concerns that need to be addressed?

4. In case of medical emergency please list specific instructions:

5. Have you ever been hospitalized? Y N

Medications:

Are you taking **any** medications (prescription or nonprescription)? Y N (*please list*)

Medical Allergies

Do you have any allergies? Y N (please list)

Medical History:

Do you have, or have ever had, any of the following conditions or symptoms? Please circle **Yes** or **No** for each condition.

1. Vision Impairment	Y N	29. Recurring lung infections	Y N
2. Hearing Impairment	Y N	30. Active Hepatitis	Y N
3. High Blood Pressure	Y N	31. History of Hepatitis B or C	Y N
4. Heart Disease	Y N	32. HIV Positive or AIDS	Y N
5. Heart Murmur	Y N	33. Unexplained Sweating	Y N
6. Elevated Cholesterol	Y N	34. Seizure Disorder	Y N
7. Irregular Heartbeat	Y N	35. Seizure within past year	Y N
8. Family history of heart attack	Y N	36. Headaches	Y N
9. Circulation Problems	Y N	37. Significant Head Injury	Y N
10. Chest Pain/Pressure	Y N	38. Learning Disability	Y N
11. Heart Palpitations	Y N	39. Frequent Dizziness	Y N
12. Shortness of Breath	Y N	40. Frequent Fainting	Y N
13. Chronic Cough	Y N	41. Diabetes	Y N
14. Asthma	Y N	42. Hypoglycemia	Y N
15. Ulcers	Y N	43. Eating Disorders	Y N
16. Intestinal Problems	Y N	44. Thyroid Problems	Y N
17. Heartburn	Y N	45. Endocrine or Gland Problems	Y N
18. Bladder Infections	Y N	46. Unexplained weight loss	Y N
19. Difficulty Urinating	Y N	47. Bleeding Disorder	Y N
20. Kidney Problems	Y N	48. Blood Disorder or Anemia	Y N
21. Obesity	Y N	49. Sickle Cell Disease or Trait	Y N
22. Arthritis	Y N	50. Cancer	Y N
23. Broken Bones	Y N	51. Skin Problems	Y N
24. Neck or Back Problems	Y N	52. Special Dietary Needs	Y N
25. Joint Problems	Y N	53. Medical Equipment/Devices	Y N
26. Muscle Cramps	Y N	54. Special Physical Requirements	Y N

27. Tuberculosis Y N 55. Psychiatric/Emotional Problems Y N
28. Exposure to TB Y N 56. Other Y N

Detailed Responses: If you answered yes to any of the questions above, explain below and/or on a separate sheet. Include the following:

- 1) What specific symptoms are occurring,
- 2) How often symptoms/conditions occur,
- 3) How long symptoms/conditions last
- 4) How you care for symptoms/conditions
- 5) How symptoms/conditions restrict your activity
- 6) Date of last occurrence

Psychosocial History:

Are you adopted? Y N

IF YES, then was this an **OPEN** or **CLOSED** adoption? (Circle one)

Have you seen a psychiatrist, psychologist, or other counselor within the past two years? Y N

Are you currently in counseling/treatment? Y N

If yes, please describe briefly on a separate sheet.

Reason for counseling (circle all appropriate responses):

Academic • Family Issues • Depression • Substance Abuse • Suicide • Adoption • Other

Primary counselor _____

Phone _____

Address _____

Have you ever used alcohol, tobacco or non-prescription drugs? Y N

If yes, please describe:

When was the last time you used alcohol, tobacco or non-prescription drugs?

Alcohol _____

Tobacco _____

Non-prescription Drugs _____

Do you feel or suspect that you may have a substance abuse problem? Y N

If yes, please explain:

Signature (Required)

The information provided above is a complete and accurate statement of the physical and psychological factors that may affect my participation in Rites of Passage Adventure Weekend (ROPA). I realize that failure to disclose such information could result in serious harm to myself and to fellow participants.

I agree to notify BTMNM should there be any changes in my health status. I authorize BTMNM to release this information to medical personnel in an emergency. I also authorize BTMNM to contact my physician or therapist to clarify any questions about my health. I understand that BTMNM reserves the right to refuse participation to anyone for medical reasons.

Signature: _____

Print Name: _____ Date: _____