DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
BUREAU OF SOCIAL SERVICES ADMINISTRATION
194 Hernan Cortez Avenue, Suite 309
Hagatna, Guam 96910-5052
Telephone No: (671) 475-2653/2672

# MEDICAL HISTORY REPORT

***Note: This form is to be completed and certified by a physician. Please type or print legibly in black or blue ink.***

Name:_____ Date of Birth: _____
(Last Name) (First Name) (M.I.)

Gender: ___ Ht: ___ Wt: ___ Eye Color: ____ Hair Color: ____ Body Mass Index (BMI): _____

| Physician's Name: | Tel No: |
|---|---|
| Name and Address of Clinic: | |

**PERSONAL HISTORY:** Please check all medical conditions below that apply:

| | Medical Condition | Past Medical History | Current Medical Condition | For every medical condition checked, briefly describe. *(Please specify the item number of the condition being described. Use the back of paper if additional space is needed).* |
|---|---|---|---|---|
| 1 | Diabetes | | | |
| 2 | High Blood Pressure | | | |
| 3 | Cancer | | | |
| 4 | Tuberculosis | | | |
| 5 | Heart Disease | | | |
| 6 | Hepatitis | | | |
| 7 | Auto-Immune Disorder | | | |
| 8 | Depression | | | |
| 9 | Anxiety | | | |
| 10 | Kidney Disease | | | |
| 11 | Skin Disease | | | |
| 12 | Seizure Disorders | | | |
| 13 | Mental Illness | | | |
| 14 | Stomach/Intestinal Disorders | | | |
| 15 | Head Injuries | | | |
| 16 | Fractures | | | |
| 17 | Hearing Impairment | | | |
| 18 | Vision Impairment | | | |
| 19 | Thyroid Disease | | | |
| 20 | Lung Disease | | | |
| 21 | Asthma | | | |
| 22 | Allergies | | | |
| 23 | Organ Transplant | | | |
| 24 | Stroke | | | |
| 25 | Pacemaker | | | |
| 26 | Degenerative Muscular Disorder | | | |
| 27 | Other(s): | | | |

Please answer Yes or No on the questions below. If "Yes", provide your comment on the space provided:

| | Yes | No | If yes, please specify (i.e., type, frequency, duration, etc). |
|---|---|---|---|
| Currently taking medication(s)? | | | |
| Any history of/current tobacco use? | | | |
| Any history of/current alcohol use? | | | |
| Any history of/current drug use? | | | |

## PHYSICIAN'S CERTIFICATION

I certify that this individual is:

[ ] Free from infectious diseases, in good health and able to provide care to a child

[ ] In poor health and unable to provide care to a child

_____ _____
Physician's Signature Date

Revised: 11/19/2009