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