Volunteering abroad programs

הלב פתוח לרווחה

Health Declaration Form

Volunteer's Name Date

Answer all questions by circling Yes (Y) or No (N) **All responses are kept confidential**

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

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7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - III. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ..... Y N
   - IV. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - V. Seizures, Convulsions, Epilepsy, Fainting or Dizziness ..... Y N
   - VI. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - XIV. Implants placed in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Sinus or Nasal problems? ..... Y N
   - XVII. ..... Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
   - XVIII. Back Pain, Difficulty lifting heavy loads? ..... Y N
8. **ARE YOU CURRENTLY USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, etc.)? ..... Y N
   - F. Tranquilizers? ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Anti-depressants, mood stabilizers, anti-psychotics Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals: _____

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9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Other allergies or reactions? Please, list ..... Y N

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10. Do you smoke or chew Tobacco? ..... Y N
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency Disorder that may affect the work you will be assigned? ..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Bearing in mind the various conditions imposed by a foreign work program (lengthy absence from home, adjustment to a foreign culture, new social contacts) do you believe that you are emotionally stable enough to participate? ..... Y N
14. Do you have any other disease, condition or problem not listed above that you think we should know about? ..... Y N
    Please elaborate: .....
    .....
15. Have you been diagnosed and/or treated for emotional problems (depression, anxiety, etc) Y N
    .....
16. Do you wish to talk to one of our doctors privately about anything? ..... Y N

I understand the importance of a truthful Health History to assist MOLSA in providing a safe environment for volunteers and patients. I have had the opportunity to discuss my Heath History with my doctor.

Date | Signature of Person Completing Health History | Doctor's signature

Doctors Information:

Name Applicant:

Date of Birth Applicant:

Place and Date:

I have examined the applicant and consider him/her physically, emotionally and mentally qualified to volunteer with ALEH in Israel.

Doctor's Stamp: Doctor's Signature: