



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

- 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 medications, herbal or holistic remedies, vitamins or minerals: _____

- 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.Y N
- Any disease, drug or transplant operation that has depressed your immune system?Y N
- XVIII. Back Pain, Difficulty lifting heavy loads?.....Y N

- 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
- 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

- 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

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 Health History with my doctor.

Date

Signature of Person Completing Health History

Physician's signature



Health Declaration Form

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: