CHINA TEACHERS PROGRAM APPLICATION

Personal Health History

To be completed by the prospective China Teacher. Please honestly answer the following questions; they will be kept confidential.

Last Name_____First Name_____Ht. (ft, in)_____Wt.(lbs) _____ Age____Sex _____

During the past year have you experienced… **If YES, give dates, frequency, and current condition**

1. Hearing or visual problems? (need for aid or glasses)..... ☐Yes ☐No
2. A need to take medications, or special diet? (Please List) ..... ☐Yes ☐No
3. Frequent headaches, dizziness, fainting or seizures? ..... ☐Yes ☐No
4. Hay fever, allergies, or asthma? ..... ☐ Yes ☐No
5. Skin sores or rashes? ..... ☐Yes ☐No
6. Warts or sores on feet? ..... ☐Yes ☐No
7. A lump, new or changing moles, or swelling? ..... ☐Yes ☐No
8. Coughing, frequent sore throat? ..... ☐ Yes ☐No
9. Chest pain or shortness of breath? ..... ☐ Yes ☐ No
10. Spitting or coughing up blood? ..... ☐ Yes ☐No
11. Sweating at night? ..... ☐ Yes ☐No
12. Stomach aches, heartburn, or indigestion? ..... ☐Yes ☐No
13. Repeated urinary infections, burning, or frequent urination? ..... ☐ Yes ☐No
14. Difficulty starting urine or dribbling? ..... ☐ Yes ☐No
15. Debilitating pain in back, neck, or joints? ..... ☐Yes ☐No
16. Difficulty walking, running, climbing stairs, or lifting ..... ☐ Yes ☐No
17. A rupture or hernia? ..... ☐ Yes ☐No
18. Unexplained weight loss? ..... ☐Yes ☐No
19. Pain or bleeding when having bowel movements? ..... ☐ Yes ☐ No
20. Frequent diarrhea, constipation, or unusual bowels? ..... ☐ Yes ☐No
21. Depression or excessive anxiety? ..... ☐ Yes ☐ No
22. Any illness or injury not already noted? ..... ☐ Yes ☐No

Numbers 23-28 for females only

23. Abnormal vaginal discharge or menstruation? ..... ☐ Yes ☐ No
24. A loss of urine when coughing or sneezing? ..... ☐ Yes ☐ No
25. Painful Menstruation? ..... ☐ Yes ☐ No
26. Spotting between periods or skipped periods? ..... ☐ Yes ☐No
27. Flowing longer than 8 days? ..... ☐ Yes ☐No
28. Treatment for PMS? ..... ☐ Yes ☐No

Have you ever had…

29. A drug or medicine reaction? ..... ☐ Yes ☐No
30. Heart disease/surgery? ..... ☐ Yes ☐ No
31. High Blood pressure? ..... ☐ Yes ☐No
32. Stroke? ..... ☐ Yes ☐No
33. Excessive bleeding? ..... ☐ Yes ☐No
34. A sexually transmitted disease? ..... ☐ Yes ☐No
35. Tumor growth, cyst, or cancer? ..... ☐ Yes ☐No
36. Diabetes, thyroid problems, or other endocrine difficulties? ..... ☐ Yes ☐ No
37. Professional counseling for emotional problems? ..... ☐ Yes ☐No
38. Medication/hospitalization for emotional problems? ..... ☐ Yes ☐ No
39. Frequently feeling sick or extremely tired? ..... ☐ Yes ☐No
40. A knee or ankle injury/surgery? ..... ☐ Yes ☐No
41. Limb loss or deformities or other handicaps? ..... ☐ Yes ☐ No
42. Severe arthritis swollen painful joints? ..... ☐ Yes ☐ No
43. External pain or pressure in chest? ..... ☐ Yes ☐No
44. Asthma or wheezing? ..... ☐ Yes ☐ No
45. Stomach or intestinal ulcers or colitis? ..... ☐ Yes ☐No
46. Unconsciousness, concussion, convulsions, or seizures? ..... ☐ Yes ☐No
47. Kidney disease or stones? ..... ☐ Yes ☐No
48. Gall bladder disease or stones? ..... ☐ Yes ☐No
49. Hepatitis, cirrhosis, or other liver problems? ..... ☐ Yes ☐ No
50. Surgery or hospitalization not listed above? ..... ☐ Yes ☐No
51. Eating problems (bulimia, anorexia)? ..... ☐ Yes ☐No
52. Suicidal thoughts or attempts? ..... ☐ Yes ☐No
53. A back injury or deformity? ..... ☐ Yes ☐ No
54. Dependency on or misuse of medication, drug or alcohol? ..... ☐ Yes ☐ No
55. Frequent loss of temper (arguments, fights)? ..... ☐ Yes ☐No
56. Difficulty learning, reading or speaking? ..... ☐ Yes ☐No
57. Feeling scared, tense, nervous, or extremely tired? ..... ☐ Yes ☐ No
58. Tuberculosis or other communicable diseases? ..... ☐ Yes ☐ No
59. Difficulty sleeping or crying spells? ..... ☐Yes ☐No
60. Other problems with your physical or mental health? ..... ☐Yes ☐ No

By signing below I attest that the above information is truthful and complete.

Signature_____Date _____