Family LIFE Center of West Michigan P.O. Box 425, Allendale, MI 49401

Health Evaluation Form

Applicant's Name: ______________________________ Date: ___________________

Date of Birth: __________________

Section One: To be filled out by applicant and reviewed by her Health Care Provider

1. List any health problems that you might have currently or have had in the past year:

2. List any surgeries that you have had:

3. Are you allergic to any foods, medications, or other things? __________
   If so, list and describe the reaction:

4. List all medications that you are currently taking:

5. How many times have you been pregnant? ________

6. Date of last period ________________or your due date__________________.

7. Do you have problems with:

Yes	No		
___	___	Eyes	(glasses, contacts, blurred vision….)
___	___	Ears	(hearing loss, earaches, hearing aides…)
___	___	Nervous System	(headaches, dizziness, seizures…)
___	___	Heart System	(racing, slow, blood pressure, swelling, chest pain…)
___	___	Lung System	(asthma, shortness of breath, TB, cough…)

If you checked "yes" to any of the above areas please explain:

8. Please fill out the dates of vaccines or attach a copy of your immunization record:

	None	1	2	3	4	Unknown
Oral Polio						
Diphtheria, Pertussis, & Tetanus (DTP)						
Measles						
Rubella						
Mumps						
Tetanus						
Hep B						

9. Family Health History – For each family member below, mark the appropriate boxes that indicate their present state of health or their death.

	Good	Poor	Deceased	Cause of Death
Father				
Mother				
Siblings				
You				

Section Two: To be filled out by the **HEALTH CARE PROVIDER**

Applicants to the Family LIFE Center need to have a physical examination which includes the requested tests since becoming pregnant.

1. Date of last physical examination:______________________
2. I have reviewed Section One of this Health Evaluation: YES NO
3. Height: _________ Weight:_________ Blood pressure: ______________
4. TB skin test (within last six months) Date:_________ Result: ________
5. STD testing including gon /Chlamydia/syphilis/HIV
   Date: ________ Result: _________
6. Any history of substance abuse, mental health problems, or emotional problems?
   YES NO
   Any abnormalities on physical exam that need further work up, referral or testing?
   YES NO
   Any restrictions on activities? YES NO
   Any known handicap or limitations? YES NO
7. If you checked "yes" to any of the catergories above, please explain.

8. Do you recommend any additional medications at this time or the discontinuation of medication that the applicant is currently taking? ________If so, please explain:

Health Care Provider's Name:____

Signature: ____________________________ Date: __________________

Address: ____