**MERCY VOLUNTEER CORPS**

**MEDICAL FORM**

**ABOUT THIS FORM**: We inquire about your health and wellness out of respect for the needs of each individual. Past medical history does not remove you from consideration; however, your openness to discussing your health and wellness helps MVC staff learn how to best support you in the upcoming year.

**INSTRUCTIONS**: The volunteer should complete this form. Those applying for U.S. placement should email this form to Marie (marieschultz@mercyvolunteers.org) *following confirmation of your placement*. Those applying for international placement should email this form to Keri (kerigardner@mercyvolunteers.org) *with your application materials*.

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**NAME:** **DATE:**

**HEALTH HISTORY: Please circle or highlight your past and current health conditions.**

Allergies

Anemia

Arthritis

Asthma

Cancer

Colitis

Diabetes

Heart Disease

Hypertension

Kidney Disease

Menstrual Problems

Migraines

Mononucleosis

Ovarian Cysts

Peptic Ulcer Disease

Seizures

Thyroid Disease

Tuberculosis

Urinary Tract Infection

Other:

Please explain the status of any conditions:

**CURRENT HEALTH STATUS: Please provide a written response to each of the questions.**

A.) Briefly describe your general state of health.

B.) Are there any health conditions which might affect your service assignment (physical challenges, chronic illnesses, restrictions, etc.)?

C.) Do you use a wheelchair, artificial limb, hearing aid, crutches or another sensory or mobility aid? Please explain.

D.) Have you ever had to modify your activities because of ill health or disability? Please explain.

E.) Have you had any operations, hospitalizations, and/or significant injuries? Please explain.

F.) List any allergies, symptoms that you experience from exposure to allergens (rash, breathing problems, etc.), and any medication you use to treat these allergies.

**PERSONAL HEALTH HABITS: Please provide a written response to each of the questions.**

A.) Do you smoke cigarettes? If yes, how many per day?

B.) Do you consume alcohol? If yes, how much and how often?

C.) Recreational/prescription drug use – list history (or occasion) of drug use:

D.) On average, how many hours of sleep do you get each night? Do you have sleeping or waking problems?

E.) How many times per week do you exercise?

F.) Dietary restrictions:

**MENTAL HEALTH: Please provide a written response to each of the questions. Use additional space if needed.**

A.) Have you received or are you receiving counseling? Please comment on the reasons for counseling, the length of time, the benefit to you, and any medication prescribed. Do you anticipate needing to continue treatment over the course of the year?

B.) Do you have a history with eating disorders or have been significantly under or overweight? Please explain.

C.) Have you ever felt suicidal or attempted suicide? Please explain.

D.) Have you ever experienced symptoms such as anxiety, depression, manic episodes, psychotic episodes, paranoia, etc? Have these symptoms been severe enough to require treatment? Please explain.

E.) Have you ever received a mental health diagnosis from a mental health professional? Please explain.

F.) If you answered “yes” to any of the above questions, what plans do you have for self-care and treatment while a Mercy Volunteer?

G.) At times MVC staff has asked volunteers to seek counseling if they display unhealthy behavior patterns. How might you respond if MVC staff recommended that you seek counseling?

 **MERCY VOLUNTEER CORPS**

**PHYSICAL FORM**

**ABOUT THIS FORM:** Mercy Volunteers provide full-time service to sites which address the needs of those who are economically poor and socially marginalized. While living in an intentional community with other volunteers, Mercy Volunteers devote themselves to a simple lifestyle and sharing spirituality. This commitment is for a year. This form will be used to assess that the applicant is fit for a full-time service placement of 40 hours per week, and to ensure they are placed where appropriate resources are available. Information disclosed in this form will be kept confidential.

**INSTRUCTIONS**: A primary care provider should complete this form, preferably one who has been involved with the individual’s ongoing care. The volunteer should follow these directions: those applying for U.S. placement should email this form to Marie (marieschultz@mercyvolunteers.org) *following confirmation of your placement* and those applying for international placement should email this form to Keri (kerigardner@mercyvolunteers.org) *with your application materials*.

**APPLICANT INFORMATION:**

Name: Date of Exam:

Length of time the applicant has been your patient:

**GENERAL PHYSICAL INFORMATION:**

A.) Height: \_\_\_\_\_\_\_\_

Weight : \_\_\_\_\_\_\_\_

 Remarks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

B.) Blood Pressure: \_\_\_\_\_\_\_\_

 Remarks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

C.) General Appearance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.) Hearing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is a hearing aid necessary? Circle one: Yes No

 Remarks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E.) Vision: Right\_\_\_\_\_\_\_ Left\_\_\_\_\_\_\_ Is correction necessary? Circle one: Yes No

 Remarks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

F.) Please describe any abnormalities or concerns next to the appropriate body system:

Neuro:

Head/ENT:

Cardiovascular:

Peripheral Neurovascular:

F. continued) Please describe any abnormalities or concerns next to the appropriate body system:

Respiratory:

Gastrointestinal:

Genitourinary:

Dermatologic:

Musculoskeletal:

Hematologic:

Endocrine:

Immune Function:

Other:

**MEDICAL HISTORY**

A.) Please note any significant medical history including past hospitalizations:

B.) List any relevant family history including physical and psychiatric conditions:

C.) List medications and reason for prescribing:

D.) List allergies and dietary restrictions:

E.) Please detail any necessary limitations or modifications for individual’s activities:
F.) Has there been a diagnosis of alcohol or drug addiction? If so, please explain.

G.) Are immunizations up-to-date? Yes No

 Has the patient received the COVID-19 vaccine? Yes No Dates of vaccination:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

H.) Do you have any medical concerns about this individual participating in Mercy Volunteer Corps? If so, please note your specific concerns below.

**PROVIDER INFORMATION**

Physician’s Name: Date:
Physician’s Signature: Address:
Phone:

*Please use name stamp or attach Rx below.*