

1	NERVOUS OR MENTAL Problems such as epilepsy, emotional stress, convulsions, loss of consciousness, dizziness, paralysis, Frequent anxiety, excessive crying. <i>If yes, please explain:</i>		
2	LUNG DISEASE Asthma, blood spitting, persistent cough, tuberculosis, abnormal chest x-rays. <i>If yes, please explain:</i>		
3	DISEASE OR HEART OR BLOOD VESSELS, INCREASED OR ABNORMAL BLOOD PRESSURE <i>If yes, please explain:</i>		
4	PAIN IN THE CHEST OR SHORTNESS OF BREATH Heart murmur, rheumatic fever <i>If yes, please explain:</i>		
5	STOMACH OR INTESTINAL TROUBLE Ulcers, gall bladder or liver disorders, jaundice, hernia, colitis. <i>If yes, please explain:</i>		
6	ARTHRITIS, DIABETES, KIDNEY OR BLADDER DISEASE <i>If yes, please explain:</i>		
7	HAY FEVER OR ALLERGIES <i>If yes, please explain:</i>		
8	ALLERGIES TO MEDICINES (including Penicillin, Tetanus) <i>If yes, please explain:</i>		
9	IMPAIRED SIGHT OR HEARING, CHRONIC EAR INFECTIONS <i>If yes, please explain:</i>		
10	RECENT SURGICAL OPERATIONS, ACCIDENTS OR INJURIES <i>If yes, please explain:</i>		
11	BEEN A PATIENT IN A HOSPITAL (other than #10) <i>If yes, please explain</i> :		
12	ANY INFECTIOUS DISEASE OR CONTACT WITH INFECTIOUS DISEASE IN THE TWO WEEKS PRIOR TO THIS TRIP. <i>If yes, please explain:</i>		
13	SKIN DISEASE <i>If yes, please explain:</i>		
14	ALLERGY TO FOODS <i>If yes, please explain:</i>		
15	MEDICATIONS YOU ARE CURRENTLY TAKING (list name and doses) <i>If yes, please explain:</i>		
16	UNDER ON-GOING CARE OF A PHYSICIAN FOR CHRONIC OR RECURRING PROBLEM (Name and telephone number of physician) <i>If yes, please explain:</i>		
17	DATE OF LAST FLU SHOT:	_____	
18	DATE OF LAST TETANUS BOOSTER:	_____	
19	LIST ANY SPECIAL NEEDS OR CONCERNS (<i>Attach additional page if need more space</i>)	_____	

**Must be completed, notarized & postmarked between November 1-7, 2011.
Send to
WI Outreach, 436 Lowell Hall, 610 Langdon St., Madison WI 53703**