



Patient Medical History - Please complete this form

Name: _____ Date of Birth: ____/____/____ Age: _____ Sex: _____

Personal Medical History:

<i>Condition / Disease</i>	<i>Condition / Disease</i>
☐ Hypertension	☐ High Blood Pressure
☐ High Cholesterol	☐ Bladder Problems
☐ Hypothyroidism (low thyroid)	☐ Anxiety
☐ COPD, Emphysema or Asthma	☐ Seizure Disorder
☐ Diabetes	☐ Bleeding Problems
☐ GERD	☐ Stroke
☐ Depression	☐ Dementia
☐ Heart Problems -	☐ Kidney Disease

<i>Medication / Food</i>	<i>Allergic Reaction</i>	<i>Medication / Food</i>	<i>Allergic Reaction</i>

☐ ***List all your medications:***

<i>Medication</i>	<i>Strength</i>	<i>Number of pills taken & frequency</i>

☐ ***List if you have taken any of the vaccines below:***

	<i>Month/Yr</i>
Flu Vaccine	
Pneumonia Vaccine	
Tetanus Vaccine	
Hepatitis B Vaccine	
Shingles Vaccine	
Meningitis's Vaccine	

Social/Cultural History: - Circle one

- ☐ Are there any hearing problems that affect your communication: YES or NO
- ☐ Are there any limitations to understanding or following instructions: YES or NO
- ☐ Any disabilities if yes, mention below: YES or NO

In case of emergency you have given the permission to be treated at the nearest health center accessible in the vicinity during your tour.

Patient Signature: _____ Date: _____

Patient Spouse or relatives whom you are authorizing to the share this information: Name: _____



YASEEN
HAJJ & UMRAH TOURS

The purpose of this form:

- In case of emergency adequate medical needs are met during your tour.
- The information provided will be kept confidential and discarded appropriately after the end of the tour.
- The information will be shared only to whom you have authorized in the form.