Georgia Youth ChalleNGe Program
MEDICAL HISTORY FORM

Applicant Name		Social Security Number	Age
Present Statement of Health	Allergies	Current Medications & Dosages	
Height	Weight	Right Handed O	Left Handed O

DO YOU HAVE OR EVER HAD:	Yes	No	If you marked yes, please explain.
Household contact with anyone who has tuberculosis			
Tuberculosis or positive TB test			
Blood in saliva or when coughing			
Excessive bleeding after injury or dental work			
Suicide attempt or plans			
Sleep-walking			
Wear corrective lenses			
Eye surgery to correct vision			
Lack vision in either eye			
Wear hearing aid			
Stutter or stammer			
Wear a brace or back support			
Scarlet fever			
Rheumatic fever			
Swollen or painful joints			
Frequent or severe headaches			
Dizziness or fainting spells			
Hearing loss			
STD/syphilis/gonorrhea, etc.			
Recent gain/loss of weight			
Loss of finger/toe			
Bed-wetting since age 12			
Kidney stone/blood in urine			
Diabetes or hypoglycemia			
Recurrent ear infections			
Severe tooth or gum trouble			

DO YOU HAVE OR EVER HAD:	Yes	No	If you marked yes, and the condition has been present in the last five (5) years, please explain.
Shortness of breath			
Chronic cough			
Palpitation or pounding heart			
Heart trouble			
High or low blood pressure			
Frequent leg cramps			
Frequent indigestion			
Stomach, liver, intestinal trouble			
Gall bladder trouble or gallstones			
Jaundice or hepatitis			
Broken bones			
Skin diseases			
Tumor, growth, cyst, or cancer			
Hernia			
Hemorrhoids or rectal disease			
Frequent or painful urination			
Eating disorder			
Thyroid trouble or goiter			
Arthritis, rheumatism, or bursitis			
Bone, joint, or other deformity			
Painful or “trick” shoulder or elbow			
Recurrent back pain or any back injury			
Trick or locked knee			
Foot trouble			
Nerve injury			
Paralysis			
Epilepsy or seizures			
Car, train, or air sickness			
Chronic depression			
Loss of memory or amnesia			
Periods of unconsciousness			
X-ray or any radiation therapy			
Chemotherapy			

DO YOU HAVE OR EVER HAD:	Yes	No	If you marked yes, and the condition has been present in the last five (5) years, please explain.	
Sinusitis or hay fever				
Asthma				
Tire easily				
Pain or pressure in chest				
Sensitivity to chemicals, dust, sunlight, etc.				
Inability to perform certain motions				
Inability to assume certain positions				
Have you ever been treated for a mental condition?				
Have you had, or have you been advised to have, any operations?				
Have you been a patient in any type of hospital?				
Have you ever had any illness or injury other than those already noted?				
Exposure to asbestos or toxic chemicals?				
Have you ever been diagnosed with a learning disability?				
Used illegal substance / Use tobacco?				
Female Only			Date of last Menstrual Period	Date last PAP smear
Treated for a female disorder				
Change in menstrual pattern				

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete

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Parent or Guardian Signature & Date