

Personal Health History of Missionary Candidate

MISSIONARY DEPARTMENT
 50 E NORTH TEMPLE ST RM 345 W
 SALT LAKE CITY UT 84150-5400

Please answer all of the following questions. Be honest with yourself, your physician, and the Lord. Major difficulties may result if this information is not complete and accurate. Please do not withhold or deny any medical information.

Your full legal name (first)	(middle)	(last)	(suffix)	Age	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
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Key: Current = is currently occurring; Previous = occurred previously, but is now resolved; Never = has never occurred

<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	1. Persisting difficulties from serious injury or deformity of your head or other body parts
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	2. Sight impairment, glaucoma, or cataracts (need for glasses or contacts; chronic eye infection)
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	3. Problems with hearing normal conversation (require a hearing aid)
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	4. Recurrent sinusitis, sore throat, ear infections, or nasal obstruction
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	5. Lung disease, emphysema, tuberculosis, shortness of breath, spitting or coughing up blood or colored sputum, or collapsed lung
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	6. Hay fever or allergies
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	7. Asthma
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	8. High blood pressure, irregular heart rhythm, heart pain, coronary artery disease, congenital heart disease, or cardiomyopathy
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	9. Varicose veins or thrombophlebitis
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	10. Heartburn, reflux, ulcers, irritable bowel, chronic diarrhea, rectal bleeding, ulcerative colitis, or Crohn's disease
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	11. Gall bladder disease or stones, hepatitis, or cirrhosis or other liver problems
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	12. Rupture (hernia), varicocele, or varices
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	13. Diabetes
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	14. Hypoglycemic attacks
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	15. Thyroid or other hormonal problems or unexplained weight loss
	16. Kidney or urinary difficulties
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	16.1. Kidney or urinary disease or stones, repeated urinary infections, burning or frequent urination, or difficulty urinating
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	16.2. Incontinence or enuresis (bed wetting)
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	17. Sexually transmitted disease
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	18. Chronic skin sores, rashes, warts on feet, changing moles, lumps, or swelling
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	19. Acne requiring Accutane
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	20. Sensitivity to the sun
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	21. Tattoos
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	22. Back or neck injury, arthritis in back or neck, spondylitis, chronic back or neck pain, or difficulty lifting things
	23. Upper extremity—loss of any part or deformity, paralysis, joint pain, arthritis, or other problem in:
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	23.1. Shoulder
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	23.2. Elbow
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	23.3. Hand or wrist
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	23.4. Other upper extremity

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24. Lower extremity—loss of any part or deformity, paralysis, joint pain, arthritis, or other problem in:					
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	24.1.	Foot	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	24.2.	Ankle	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	24.3.	Knee	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	24.4.	Hip	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	24.5.	Other lower extremity (such as ingrown toenails)	
25. Frequent or severe headaches:					
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	25.1.	Migraine headaches	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	25.2.	Tension headaches	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	25.3.	Frequent mild headaches	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	25.4.	Other headaches	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	26.	Unconsciousness from head injury or interference with coordination or skilled movements; weakness or sensory loss from illnesses such as Parkinson's disease, multiple sclerosis, stroke, and so on	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	27.	Fainting, dizziness, convulsions, seizures, or hyperventilation	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	28.	Frequent feelings of being sick or easily tired, anemia, or bleeding tendency	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	29.	Chronic fatigue syndrome or fibromyalgia syndrome	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	30.	Insomnia or difficulty sleeping	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	31.	Tumors, cancers, leukemia, chemotherapy, radiation therapy, or organ transplantation	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	32.	Reaction or allergy to drug or medication	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	33.	Taking medications (prescriptions, over the counter drugs, or vitamins and supplements)	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	34.	Other diseases or problems with your physical health not already noted, including family history of tuberculosis or other disease	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	35.	Surgery, hospitalization, or injuries not listed above	
36. Learning difficulties:					
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	36.1.	ADD or ADHD	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	36.2.	Dyslexia	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	36.3.	Pervasive developmental disorder (Asperger's disorder, autism)	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	36.4.	Reading disorder	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	36.5.	Other learning disorders (including speech disorders)	
37. Emotional difficulties:					
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	37.1.	Anxiety	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	37.2.	Bipolar disorder	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	37.3.	Depression	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	37.4.	Obsessive-compulsive disorder	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	37.5.	Panic attacks	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	37.6.	Separation anxiety (homesickness)	
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input type="checkbox"/> Never	37.7.	Other changing moods, anxieties, nervousness, or depressions	

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<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	38. Difficulty in relationships due to temper, moods, or habits (fights or aggressive behavior)				
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	39. Schizophrenia or psychosis				
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	40. Eating disorders— <i>anorexia, bulimia, or obesity</i>				
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	41. Abuse of or dependency on prescription or over-the-counter medications, recreational drugs, or alcohol				
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	42. Been a victim of physical, sexual, or emotional abuse				
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	43. Undiagnosed aches and pains				
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	44. Counseling, treatment, or hospitalization for emotional problems				
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	45. Other emotional problems				
<input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	46. Endometriosis, painful menstruation, abnormal vaginal discharge, uterine or ovarian tumors or cysts				
<input type="checkbox"/> Yes <input type="checkbox"/> No	47. Can work 12 to 15 hours per day, walk 6 to 8 miles per day, ride a bicycle 10 to 15 miles per day, and climb stairs daily				
<input type="checkbox"/> Yes <input type="checkbox"/> No	48. Will receive immunizations				

Declaration and Authorization by Missionary Candidate

I declare that the statements made in the Personal Health History of Missionary Candidate are a complete and honest report of my health history. No personal health information has been withheld or misrepresented.

I hereby authorize The Church of Jesus Christ of Latter-day Saints to collect, process, and transfer to other countries for Church purposes my personal data, including explicit sensitive data, in accordance with the Church Data Privacy Policy.

Missionary candidate's signature	Date
Parent or guardian's signature	Date