

**NATIONAL SPIRITUAL ASSEMBLY  
OF THE BAHÁ'ÍS OF AUSTRALIA INCORPORATED**

A.R.B.N. 009 727 128 (Incorporated in the A.C.T.) (Liability of members is limited)

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In reply please quote ref. no.:

**CONFIDENTIAL**

**HEALTH QUESTIONNAIRE FOR BAHÁ'Í YOUTH YEAR OF SERVICE**

Name \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Have you ever had, or do you now have, any of the following? Answer questions carefully and fully explain, in the space provided, all those questions to which you answered "Yes". You may attach additional sheets as necessary.

- |                                     |  |       |
|-------------------------------------|--|-------|
| 1. Severe headaches                 | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 2. Eye trouble                      | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 3. Ear trouble                      | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 4. Allergies/Hay fever              | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 5. Thyroid disorder                 | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 6. Asthma                           | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 7. Other lung or breathing problems | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 8. High blood pressure              | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 9. Heart trouble                    | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 10. Trouble with arteries/veins     | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 11. Bleeding/Clotting problems      | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 12. Anomia/Sickle cell trait        | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 13. Kidney/Bladder problems         | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 14. Stomach/Duodenal ulcer          | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 15. Hepatitis/Other liver problems  | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 16. Gall Bladder/Pancreas problems  | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 17. Intestinal disorders            | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 18. Haemorrhoids/Rectal problems    | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 19. Parasites                       | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 20. Hernia                          | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 21. Prostate/Testicle problems      | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 22. Uterus/Ovary problems           | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 23. Arthritis/Bursitis              | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 24. Back trouble/Sciatica           | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 25. Other joint problems            | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 26. Epilepsy                        | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 27. Other neurological disorders    | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 28. Fainting spells                 | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 29. Recurring dizziness             | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 30. Mental/Nervous conditions       | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 31. Skin conditions/Chronic rash    | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 32. Disorder of the immune system   | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| 33. Rheumatic fever                 | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |

34. Tuberculosis/Positive T.B. test No Yes \_\_\_\_\_
35. Malaria No Yes \_\_\_\_\_
36. Diabetes No Yes \_\_\_\_\_
37. Tumour/Cancer No Yes \_\_\_\_\_
38. Blood transfusions No Yes \_\_\_\_\_
39. Physical handicaps No Yes \_\_\_\_\_
40. Have you ever received psychotherapy? No Yes \_\_\_\_\_
41. Are you currently under a doctor's care? No Yes \_\_\_\_\_
42. Have you ever had any serious illness or injury? No Yes \_\_\_\_\_
43. Do you smoke? No Yes \_\_\_\_\_
44. Other \_\_\_\_\_

List medications (prescription/non-prescription) you currently take: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever been hospitalised for any illness, injury or operation? No Yes

If "Yes" please list, giving reasons and dates: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When was the date of your last...?

Physical Examination	( dd / mm / yyyy )	Gynaecological Examination	( dd / mm / yyyy )
Dental Examination	( dd / mm / yyyy )	Tetanus Booster	( dd / mm / yyyy )
Measles (Rubeola) Vaccine	( dd / mm / yyyy )		

In case of illness or accident, whom should we notify? (next of kin)

Name \_\_\_\_\_

Street Address \_\_\_\_\_

Town \_\_\_\_\_ State \_\_\_\_\_

Post Code \_\_\_\_\_ Country \_\_\_\_\_ E-Mail \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ Fax \_\_\_\_\_

In the event of a serious accident or fatality I wish to remain in my pioneering post. No Yes

Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I, (please print full name clearly) \_\_\_\_\_, hereby declare that all of the information presented on this health questionnaire is complete, honest and accurate.

Signature \_\_\_\_\_ Date \_\_\_\_\_