Ministry of Labor
Social Affairs and Social Services

תחום התנדבות
משרד הרווחה

Health Declaration Form

Volunteer's Name Date

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? ....Y N
2. Has there been any change in your general health in the past year? ....Y N
3. Date of last physical exam ____________________
4. Are you now under a physician's care for a particular problem? ....Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe:..............Y N

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7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease?.....Y N
   - B. Congenital Heart Disease? ....Y N
   - III. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ....Y N
   - IV. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ....Y N
   - V. Seizures, Convulsions, Epilepsy, Fainting or Dizziness...Y N
   - VI. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?............Y N
   - G. Liver Disease (Jaundice, Hepatitis)?......................Y N
   - H. Kidney Disease? ....Y N
   - I. Diabetes?...Y N
   - J. Thyroid Disease (Goiter)?.......................................Y N
   - K. Arthritis?..Y N
   - L. Stomach Ulcers or Colitis?......................................Y N
   - M. Glaucoma?...Y N
   - XIV. Implants placed in your body (Heart Valve, Pacemaker, Hip, Knee)? ....Y N
   - O. Radiation (X-ray) treatment for Cancer? ....Y N
   - P. Sinus or Nasal problems? ....Y N
   - XVII. .... Any disease, drug or transplant operation that has depressed your immune system? ....Y N
   - XVIII. Back Pain, Difficulty lifting heavy loads?..............Y N
8. **ARE YOU CURRENTLY USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?...Y N
   - B. Anticoagulants (Blood Thinners)? ....Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.Y N
   - D. High Blood Pressure medications? ....Y N
   - E. Steroids (Cortisone, etc.)? ....Y N
   - F. Tranquilizers? ....Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ....Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Anti-depressants, mood stabilizers, anti-psychotics Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:_______

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9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? ....Y N
   - B. Penicillin or other antibiotics? ....Y N
   - C. Sedatives, Barbiturates?..Y N
   - D. Aspirin or Ibuprofen?..Y N
   - E. Codeine or other pain killers? ....Y N
   - F. Latex or Rubber Products? ....Y N
   - G. Other allergies or reactions? Please, list................Y N

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10. Do you smoke or chew Tobacco?.................................Y N
    How much per day? _________
11. Is there any past history of Alcohol or Chemical Dependency Disorder that may affect the work you will be assigned?...Y N
12. Have you had any serious problems associated with any previous dental treatment?.....................................Y N
13. Bearing in mind the various conditions imposed by a foreign work program (lengthy absence from home, adjustment to a foreign culture, new social contacts) do you believe that you are emotionally stable enough to participate? ....Y N
14. Do you have any other disease, condition or problem not listed above that you think we should know about? ....Y N
    Please elaborate:……………………………………………
    ………………………………………………………………
15. Have you been diagnosed and/or treated for emotional problems (depression, anxiety, etc) Y N
    ………………………………………………………………
16. Do you wish to talk to one of our doctors privately about anything? ....Y N

I understand the importance of a truthful Health History to assist MOLSA in providing a safe environment for volunteers and patients. I have had the opportunity to discuss my Heath History with my doctor.

Date | Signature of Person Completing Health History | Physician's signature