

**Crossroads Himalaya
Confidential
Medical and Physical Examination Record**

1. Name _____
3. Birth date ___/___/___
4. Height _____ ft. _____ in. Weight _____ lbs.
5. Male ___ Female ___
6. Address _____
City/State/Zip _____
Home Phone _____
7. Physician _____
Phone _____ Fax _____
8. In case of emergency contact _____
Relationship _____
Contact's address _____
City/State/Zip _____
phone _____ Eve phone _____ Day _____
11. Personal medical/hospitalization policy information
Insurance Company _____
Policy and personal ID # _____
Address _____
City/State/Zip _____

Does your insurance company require pre-authorization? Y__ N_____
If yes, phone _____ (Note: toll-free numbers do not work from
abroad).

You must be fully covered by health insurance for the duration of the trip and your policy must include: personal injury, medical expenses abroad, emergency medical evacuation, death and repatriation. We also suggest you take out trip insurance too, to cover such curtailments as theft/loss of luggage/equipment and cancellations.

Participant History: Past and Present Medical Problems

Fill in EVERY blank. Use additional pages if necessary.

A. Conditions and Symptoms

Do you have, or have you had, any of the following conditions or symptoms:

Yes No

1. High Blood Pressure
2. Low Blood Pressure
3. Heart Disease
4. Heart Murmur
5. Irregular Heartbeat
6. Family history of heart attack
7. Tuberculosis
8. Recent exposure active TB/Positive TB test
9. Active Hepatitis
10. Seizure Disorder Epilepsy
11. Seizure within past year
12. Bleeding Disorder
13. Blood disorder/anemia/sickle cell trait
14. Hypoglycemia
15. Diabetes
16. Thyroid problem
17. Chronic cough
18. Recurrent lung infections
19. Asthma
20. Bulimia
21. Cancer
22. Skin Problem
23. Frostbite
24. Circulation Problems
25. Active Bedwetting
26. Headaches
27. Head injury w/neurological impairment
28. Stomach Ulcers
29. Intestinal Problems
30. Heatstroke
31. Bladder Infection
32. Difficulty Urinating
33. Kidney Problems
34. Endocrine Problems
35. Vision Impairment
36. Hearing Impairment
37. Hernia
38. Joint dislocations/serious sprains
39. Motion Sickness
40. Sleep Walking
41. Broken Bones
42. Neck Problem
43. Back Problem
44. Arm Problem
45. Shoulder Problem
46. Knee Problem
47. Ankle Problem
48. Leg Problem
49. Foot Problem
50. Current Pregnancy
51. Special Diet
52. Learning Disability
53. Medical Equipment/Devices

- 54. Unexplained weight loss
- 55. Chest Pain Pressure
- 56. Blindness
- 57. Heart Palpitations
- 58. Unexplained Sweating
- 59. Frequent Shortness of Breath
- 60. Frequent Fainting
- 61. Frequent Dizziness
- 62. Frequent Convulsions
- 63. Heartburn
- 64. Muscle Cramps
- 65. Joint swelling, pain, stiffness
- 66. Intolerance to warm temps
- 67. Intolerance to cold temps
- 68. PMS or menstrual problems
- 69. Frequent diarrhea or blood in stool

If you have answered “yes” to any of the above items, please explain below. Include the following:

- Specific symptoms and how often conditions occurs
- How symptom/condition restricts activity in any way, including your ability to run, lift, etc.
- How long symptom/condition lasts and how you can care for the symptom/condition
- Date of last occurrence

(Item No.) Detailed Description

() _____

() _____

() _____

() _____

B. Allergies - NONE

List any allergies you have, including medicines, foods, bites/stings:

Allergy	Reaction	Medication Required

C. Medication - NONE

List any medications you are using, including psychiatric and over-the-counter medication:

Medication	Condition	Dosage & Frequency	Side Effects

Note: If you are taking medication, pack double amounts in separate, non-breakable, water-proof containers along with dosage instructions.

D. Hospitalizations / Emergencies - NONE

List any hospital or emergency room visits in the last two years:

Dates	Reason	Length of Stay

E. Personal History

1. Have you been to counseling with a psychiatrist, psychologist, or other counselor within the past two years? Yes No

2. Are you currently in counseling treatment? Yes No

3. When was the counseling terminated? Date _____

Reasons for termination (check appropriate responses):

Academic

Family issues

Depression

Substance Abuse

Career

Family divorce

Suicide

Other

4. Have you arranged for a release of information with your counselor so that we may contact him/her? Yes No

5. Name of most recent counselor

6. Phone _____

G. Lifestyle

1. Do you use alcohol? Yes No
How much/how often?

2. Do you use tobacco? Yes No
How much/how often?

3. Do you currently have a substance abuse problem (alcohol or drugs)? Yes No
If yes, please describe _____

4. Do you have a history of chemical dependency? Yes No
Drugs _____ Date last used _____

H. Current Exercise Activity

List current exercise activity:

Activity	Frequency	Approximate Time/Distance	Leisurely	Moderate	Intensive

F. Consent to Terms:

Permission is given for any emergency anesthesia, operation, hospitalization or other treatment that might become necessary. All information will remain confidential. Participants with a variety of medical/psychological difficulties can attend the tour, but we must be aware of these conditions. Failure to disclose such information could result in serious harm to you and fellow members of the group. If you depart on a tour with a pre-existing condition or injury that is not indicated on your medical form and you are subsequently forced to leave the trip because of that condition, you will be charged an evacuation fee and will not receive a refund of trip cost.

Participant Signature

Date

Print Name