**Health Check Card**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | M / F |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. Do you get sick easily? | | | | | YES / NO | |
| If so, please give details. | |  | | | | |
| 2. Do you catch a cold easily? | | | | | YES / NO | |
| If so, what kind of symptoms do you have?  What medicine do you take/ Are you taking now? | |  | | | | |
| 3. Do you get an upset stomach easily? | | | | | YES / NO | |
| If so, what kind symptoms do you have? What medicine do you usually take/are you taking now? | |  | | | | |
| 4. Do you get anemia easily? | | | | | YES / NO | |
| 5. Are you a vegetarian? | | | | | YES / NO | |
| If so, what do you do? | |  | | | | |
| 6. Do you find it hard to sleep in a new environment? | | | | | | YES / NO |
| 7. Do you have any allergies? | | | | | | YES / NO |
| Food Allergy | What? | |  | measure? | |  |
| Medicine Allergy | What? | |  | measure? | |  |
| Other | What? | |  | measure? | |  |
| 8. Have you ever had a serious illness or are you ill now? | | | | | | YES / NO |
| Name of illness | |  | | | | |
| Since when | |  | | | | |
| Present condition | |  | | | | |
| Medicine you are taking | |  | | | | |
| Measures you take | |  | | | | |
| 9. Do you ever feel unstable when your environment changes? | | | | | | OFTEN / SOMETIMES/ RARELY |
| If you answered OFTEN or SOMETIMES then please write about how you deal with it. | |  | | | | |
| 10. Are there any other medical conditions or instructions you have received from your doctor? | | | | | | |
|  | |  | | | |  |

Date:

I hereby declare that the statement is true and correct. Signature: