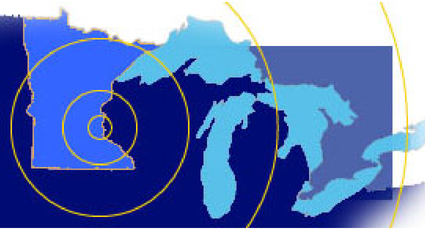

MN-1 DMAT HEALTH HISTORY/ASSESSMENT

Name ____Date: ________________________
Address ____
City/State/Zip____
Phone: Home _____________________ Other _____________________________________
Team Position ____
DOB __________________ Sex _________
Emergency Contact Name: _____________________________ Phone _______________

CURRENT MEDICAL PROBLEMS (circle Yes or No)

ASTHMA/ALLERGIES	YES	NO	KIDNEY DISEASE	YES	NO
DIABETES	YES	NO	LIVER DISEASE	YES	NO
EPILEPSY	YES	NO	ANEMIA	YES	NO
HEART DISEASE	YES	NO	CANCER	YES	NO
HYPERTENSION	YES	NO	BACK/NECK INJURY	YES	NO
STROKE	YES	NO	BONE/JOINT DISEASE	YES	NO
BLEEDING TENDENCY	YES	NO	WORK RESTRICTIONS	YES	NO
THYROID DISEASE	YES	NO	OTHER ILLNESS	YES	NO

Explain any yes answers:____
____
____

Current Medications: ____
____
____

Drug Allergies: ____
____

Other Allergies (latex, bee stings, etc): ____
____

Past Major Illnesses: ____
____

Past Surgery: ____

____

Anesthesia Problems: ____

Do you currently have any dental problems? ☐Yes ☐No
If yes explain:____

____

Females only: Are you pregnant? ☐Yes ☐No If yes, LMP ___________________

Personal Physician Name and phone number:

____

Personal Dentist Name and phone number:

____

Pre-Deployment

Do you currently have any questions or concerns about your health?

____

____

Do you have a 21-day supply of your medications? ☐NA ☐Yes ☐No

Do you have an extra pair of glasses, contacts, hearing aid/batteries? ☐NA ☐Yes ☐No

Are your immunizations up-to-date? ☐Yes ☐No

Do you have concerns about possible exposures or events during this deployment that you feel may affect your physical or mental health? ☐Yes ☐No
If yes, explain:____

____

PHYSICIAN'S FINDINGS

____

____

____

____

☐Deployable ☐Not deployable Dr.________________________________

Post Deployment

Do you have any unresolved medical, dental, or psychological concerns from this deployment? ☐No ☐Yes If yes explain:

____

____

____

Do you have any work or medical restrictions from this deployment? ☐No ☐Yes
If yes explain: ____

____

____

Team member's signature ____________________________________Date_____________