VETERAN MEDICAL INTERVIEW

A member of our Medical Team will be reviewing this form. If they have any questions or concerns, a member of the team will contact you by telephone to discuss further.

VETERAN NAME: **IMPORTANT! Put name EXACTLY as it appears on your Driver's License or I.D.**

First: _____

Middle: _____ **Last:** _____

Birthdate: _____ / _____ / _____
Month *Date* *Year*

Age: _____ **Gender:** ☐ **Male** ☐ **Female** **WEIGHT:** _____ **lbs.**

HOME PHONE: ( ) —
area code

CELL PHONE: ( ) —
area code

EMERGENCY CONTACT: **First:** _____

Last: _____

Relationship: _____

HOME PHONE: ( ) —
area code

CELL PHONE: ( ) —
area code

CONTINUED ▶

HEALTH HISTORY: DIAGNOSIS AND CONDITIONS

MEDICATIONS - Please list below OR attach list provided by your Doctor.

	MEDICATION:	DOSE:	TIME:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

CONTINUED ▶

MEDICATION ALLERGIES:

_____

FOOD ALLERGIES:

_____

CURRENT SEIZURE DISORDER?	☐ **YES**	☐ **NO**
RECENT SURGERY ?	☐ **YES**	☐ **NO**
RECENT CARDIAC EVENT?	☐ **YES**	☐ **NO**
RECENT STROKE EVENT?	☐ **YES**	☐ **NO**
CURRENT CANCER?	☐ **YES**	☐ **NO**
DO YOU HAVE URINARY INCONTINENCE ?	☐ **YES**	☐ **NO**
DO YOU HAVE STOOL INCONTINENCE ?	☐ **YES**	☐ **NO**
DO YOU HAVE DEMENTIA?	☐ **YES**	☐ **NO**
DO YOU HAVE ALZHEIMER'S?	☐ **YES**	☐ **NO**
ANY PRIOR ADVERSE TRAVEL EXPERIENCE?	☐ **YES**	☐ **NO**

CONTINUED ▶

MOBILITY: WHEELCHAIR/WALKER/CANE REQUIREMENTS

DO YOU HAVE THE ABILITY TO WALK FROM PLANE, TO BUS, TO WHEELCHAIR? ☐ YES ☐ NO

DO YOU CURRENTLY USE ANY OF THE FOLLOWING MOBILITY EQUIPMENT?

☐ CANE ☐ WALKER ☐ WHEELCHAIR

WILL YOU NEED A WHEELCHAIR?

☐ ALL DAY ☐ AS NEEDED (PLEASE RESERVE ME A WHEELCHAIR IN CASE I NEED IT.)

WC

DO YOU REQUIRE OXYGEN? ☐ YES ☐ NO

RATE:_____ **L/MIN**_____

IF YES: ☐ PART-TIME ☐ FULL-TIME

O2

DO YOU HAVE A SIGNED DNR FORM? *(Do-Not-Resuscitate Form)* ☐ YES ☐ NO

FORM is ONLY needed if your wish is NOT to be resuscitated. Veteran MUST provide a copy of form to GPHF Medical Team.

DNR

PRI SCORE:
(To be filled out by GPHF Medical Team)

I authorize the Greater Peoria Honor Flight, organization, its officers, employees, members, participants, users and/or volunteers to take action they believe is appropriate in an emergency situation. Further, I agree to indemnify and hold harmless the Greater Peoria Honor Flight, organization, its officers, employees, members, participants, users and/or volunteers thereof, against any claim(s) arising out of said emergency care. I authorize Greater Peoria Honor Flight medical staff to contact my physician or family to update, verify or clarify medical information for the purpose of medical support during GPHF travel. This information may be shared with your Guardian.

SIGNATURE: _____ ***Date:*** ____/____/____