MEDICAL HEALTH CONDITION REPORT OF AIU EMPLOYEE (CONFIDENTIAL)

Full name: _____

Address: _____ Employee ID: _____

Phone/Mobile: _____ Emergency contact number: _____

Date of birth: _____ Marital status: _____

Spouse name: _____ Spouse day contact number: _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Do not leave any blank unanswered. Please provide explanations for all "yes" responses under remarks.

Yes	No		Yes	No	
¨	¨	Arteriosclerosis	¨	¨	Epilepsy
¨	¨	Arthritis	¨	¨	Head Injury
¨	¨	Asthma	¨	¨	Heart Condition
¨	¨	Back/Neck Problem	¨	¨	High/Low Blood Pressure
¨	¨	Cancer	¨	¨	Hyperinsulinism
¨	¨	Cardiac Disease	¨	¨	Hypertension
¨	¨	Cerebral Vascular Accident	¨	¨	Kidney Disorder
¨	¨	Chronic Osteomyelitis	¨	¨	Mental Disorders
¨	¨	Chronic Headaches	¨	¨	Nervous Disorders
¨	¨	Dizziness	¨	¨	Numbness of Extremities
¨	¨	Double Vision (blurred sight)	¨	¨	Rheumatism
¨	¨	Emphysema	¨	¨	Thrombophlebitis

REMARKS: If you answered "yes" to any question above, indicate the nature of the injury/illness, name and address of the treating health care provider in Kuwait (you may submit later to the clinic), area of specialty and approximate date/year of the illness/injury.

_____

_____

Are you presently or have you ever been under the care of a doctor or other health care provider for any serious injury, disability or medical condition?

¨ **YES** ¨ **NO**

If yes, please list the condition, injury or illness(s) being treated, the name of the doctor(s), field of specialty, telephone number (if in Kuwait), and dates of last treatment.

_____

_____

Are you presently taking or have you ever taken any medication for any serious injury, disability or medical condition?

¨ **YES** ¨ **NO**

If yes, please list the name or type of medication, the medical condition being treated, and the name, address and telephone number of the physician who prescribed the medication, area of specialty, and dates of treatment.

I UNDERSTAND THAT MY FAILURE TO TRUTHFULLY ANSWER ANY OF THE ABOVE QUESTIONS MAY RESULT IN AFFECTING THE DELIVERY OF MEDICAL ASSISTANCE AND SUPPORT FOR ME.

SIGNATURE: _____ **DATE:** _____