Applicant Reference Form

Physician/Health Care Professional

Name of Applicant: _____

Part A: Self-Report (This section is to be filled out by the applicant)

TO THE APPLICANT: This information is treated confidentially. Please answer all questions in ink or type in English. Arrange to complete **Part B** through your physician and instruct them to mail or fax this form to the Servant Partners office. If you have any further, questions please contact our office at (626) 398-1010.

PERSONAL HISTORY

1) Do you have or have you ever had any of the following? If yes, check box and comment on next page.

- ❑ Skin Conditions
- ❑ Jaundice
- ❑ Ear Trouble
- ❑ Eye Trouble
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Diabetes
- ❑ Kidney Disease
- ❑ Head Injury
- ❑ Gall Bladder Problems
- ❑ Anemia
- ❑ Recurrent Headache
- ❑ Venereal Disease
- ❑ Epilepsy
- ❑ Asthma
- ❑ Hay Fever
- ❑ Shortness of Breath
- ❑ Fainting Spells
- ❑ Heart Trouble
- ❑ Tumor/Cancer
- ❑ Stomach/Duodenal Ulcer
- ❑ Mental or Nervous Disorders
- ❑ Hepatitis
- ❑ Weakness
- ❑ Intestinal Trouble
- ❑ Recurrent Diarrhea
- ❑ Rheumatism/Arthritis
- ❑ Insomnia
- ❑ Back Problems
- ❑ Dislocation of Joints
- ❑ Broken Bones
- ❑ Paralysis
- ❑ Surgery
- ❑ Appendectomy
- ❑ Tonsillectomy
- ❑ Hernia Repair

FEMALES ONLY

- ❑ Irregular Periods
- ❑ Severe Cramps
- ❑ Excessive Flow

Allergy:

- ❑ to Penicillin
- ❑ to Sulphonamides
- ❑ to Serum
- ❑ Other Allergies: _____
- ❑ Food Allergies (specify): _____
- ❑ Other (specify): _____

Are you pregnant?

- ❑ Yes
- ❑ No

Comments:

2) Are you at present under a doctor's care for any reason? If yes, please explain:

3) Are you taking any medication at this time?

4) Do you now or have you ever received any compensation for disability from any source?

5) Have you ever sought treatment for any sort of mental illness?

6) Have you ever sought treatment for an eating disorder?

7) Have you ever had any of the following communicable diseases? If yes, please give dates.

Dates:

- ❑ Chickenpox: _____
- ❑ Scarlet Fever _____
- ❑ Measles (Rubella) _____
- ❑ Tuberculosis _____
- ❑ Mumps _____
- ❑ Pertussis (Whooping Cough) _____
- ❑ Other (specify): _____

FAMILY HISTORY

8) Have you or anyone in your family had any of the following? If yes, please describe fully.

- ❑ Tuberculosis
- ❑ Diabetes
- ❑ Kidney Disease
- ❑ Heart Disease
- ❑ Arthritis
- ❑ Stomach Disease
- ❑ Asthma
- ❑ Hay Fever
- ❑ Epilepsy/Convulsions
- ❑ Mental Illness

Comments:

Part B: Physician's Evaluation (This section is to be filled out by the physician)

TO THE PHYSICIAN: Please review the information in Part A. Please indicate all conditions that require treatment and notify us of any problems that you feel merit follow-up by the health services.

First Name	Last Name		
Office Address	**City**	**State**	**Zip Code**
Phone	**Fax**	**E-mail**	
How long have you known the applicant (in years & months)?			

Applicant's Health Information			
Height (inches):		**Weight (pounds)**	
Overweight?		**Underweight?**	
Blood Pressure:		**Color Perception:**	

Are there any abnormalities of the following systems? If yes, please describe fully.

- ❑ Eyes
- ❑ Teeth
- ❑ Neuro-Psychiatric
- ❑ Cardiovascular
- ❑ Respiratory
- ❑ Trunk and Back
- ❑ Hernia
- ❑ Musculoskeletal
- ❑ Endocrine
- ❑ Lymphatic
- ❑ Skin
- ❑ Head
- ❑ Ear, Nose, Throat
- ❑ Pelvic

Comments:

PHYSICIAN'S RECOMMENDATION (Indicate one):

- ❑ Acceptable without limitations
- ❑ Acceptable with limitations (specify):
- ❑ Acceptable, but should remain in areas where adequate medical care is provided (specify):
- ❑ Not acceptable (specify):

Signature: _____ Date: _____

Please mail or fax this form to:

Servant Partners
P.O. Box 3144
Pomona, CA 91769
Telephone: (626) 398-1010
Fax: (626) 398-1028

Thank you very much for your prompt response!