

American University of Beirut Medical Center

Executive Health & Travel Center

② Information About Your Personal Physician

First Name

Last Name

Mailing Address

City

Country

E-mail:

Area Code - No.

Mobile:

Business :

Fax :

Would you like us to send a copy of your final medical report to your personal physician?

Yes

No

If yes, please print date and sign your name below:

Date

Month

Year

Signature:

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③ Your Current Medical Problems

Problem	Date of Onset	Present status

Current Medications

Please list all medications that you are currently taking - including insulin, oral contraceptives, vitamins, diet supplements, herbal preparations, etc.)

Medication	Dosage	Doses per Day	Date started

Please List any known adverse reactions/allergies you had to any medications or food items:

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④ Your Past Medical History

Please indicate below if you have had one or more of following problems as a child or adult:

- | | |
|--|---|
| <input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Hernia
<input type="checkbox"/> Cancer/Tumor
<input type="checkbox"/> Chronic Cough
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Joint Problems
<input type="checkbox"/> Kidney/Urinary Problems | <input type="checkbox"/> Epilepsy
<input type="checkbox"/> Hearing Problems
<input type="checkbox"/> Jaundice or Hepatitis
<input type="checkbox"/> Visual problems
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Asthma
<input type="checkbox"/> Other - Specify : _____ |
|--|---|

Immunization Record:

Please bring a copy of your immunization record or any other related document if available.

⑤ Family Medical History

Does any member of your family have/had one or more of the following:

	Father	Mother	Other - Specify
<input type="checkbox"/> Cancer - Specify :	
<input type="checkbox"/> Diabetes			
<input type="checkbox"/> Stroke			
<input type="checkbox"/> Heart Attack / Diseases			
<input type="checkbox"/> Hypertension			
<input type="checkbox"/> Other - Specify:			

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⑥ Personal Habits

Tobacco:

1- Have you ever used tobacco regularly? Yes No

2- How long have you been smoking?: years

3- Do you currently use tobacco? Yes No

If you smoke cigarettes, how many per day?

If you smoke cigars, how many per day?

If you smoke hubble-bubble, how many hours per day?

Alcohol:

1- Do you take alcoholic beverages? Yes No

2- If yes, for how long have you been taking alcohol ?

Physical Exercise:

1- How often do you exercise?

Never Rarely Once a week Several times a week Daily

2- What exercises you do?
.....

Please Complete and Send to :
Executive Health and Travel Center
Fax: + 961 1 365 168
E-mail : ehc@aub.edu.lb