

 **USS Abraham Lincoln NCC 71809 - A**

 **Celebrating Over 58 Years of Star Trek’s Exploration of Space**

 

All information on this for is confidential between the crewmember and the CMO, Executive Officer and

Commanding Officer Keith S. Shikowitz

CREW MEMBER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT’S NAME: (IF CREWMEMBER UNDER 18) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician name and phone number:

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please fill in all of the appropriate information about the member’s health. Check the appropriate space. Add separate sheet of paper where necessary.

1. Has anyone in your family under age 45 died suddenly? \_\_\_ Yes \_\_\_ No

2. Have you ever had:

 Concussion or been knocked out? \_\_\_ Yes \_\_\_ No

 Fainting? \_\_\_ Yes \_\_\_ No

 Heat Stroke? \_\_\_ Yes \_\_\_ No

 Epilepsy, seizures or fits? \_\_\_ Yes \_\_\_ No

 Head or neck injury? \_\_\_ Yes \_\_\_ No

 Hearing loss or deafness? \_\_\_ Yes \_\_\_ No

 Sinus problems or Hay Fever? \_\_\_ Yes \_\_\_ No

 Allergies? \_\_\_ Yes \_\_\_ No Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Food allergies? \_\_\_ Yes \_\_\_ No Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Broken bones? \_\_\_ Yes \_\_\_ No

 Serious foot problems? \_\_\_ Yes \_\_\_ No

 Ankle or knee problems? \_\_\_ Yes \_\_\_ No

 Diabetes? \_\_\_ Yes \_\_\_ No (type 1 type 2)

 Single illness for more than 10 days? \_\_\_ Yes \_\_\_ No

 Operations? \_\_\_ Yes \_\_\_ No Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Easy bruising or bleeding tendencies? \_\_\_ Yes \_\_\_ No Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Anemia? \_\_\_ Yes \_\_\_ No

 Asthma? \_\_\_ Yes \_\_\_ No

 Heart trouble or murmurs? \_\_\_ Yes \_\_\_ No

 Chest pain or faintness with exercise? \_\_\_ Yes \_\_\_ No

3. Do you wear glasses or contacts? \_\_\_ Yes \_\_\_ No

4. Do you take any medications? \_\_\_Yes \_\_\_ No Specify (name & doses) Attach extra sheet if necessary:

 NAME OF MEDICATION DOSE

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 PRIMARY CARE PHYSICIAN

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 NAME PHONE NUMBER

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 CREW MEMBER’S SIGNATURE DATE

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 PARENT’S SIGNATURE (IF CREWMEMBER UNDER 18) DAT