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GOVERNOR

**RAY TENORIO**  
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**JAMES W. GILLAN**  
DIRECTOR

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DEPUTY DIRECTOR

The Island of Guam and its people are excited to host the 12<sup>th</sup> Festival of Pacific Arts in 2016 and welcome all Festival participants and visitors enthusiastically! To ensure the health and welfare of all participants, you are asked to complete and bring with you this **voluntary Festpac Medical Intake Form**.

**\*\*NOTE - This Checklist is NOT a requirement for participation however it is a valuable document that will assist us to provide you with the appropriate care and assistance if/when needed and will only be asked for at that time.\*\***

**Other HELPFUL HEALTH TIPS to consider as you complete this checklist:**

- Ensure all your immunizations are up-to-date prior to travelling.
- Bring ample supply of any necessary medications, to include your prescription documents.
- Bring your health/medical insurance card or information, if applicable. If you are eligible for military health benefits, bring your DoD-issued Identification Card.
- Familiarize yourself with the “Aid Stations” upon arrival to the Festival grounds. These Aid Stations will be available to assist all participants who may need medical assistance.

**THANK YOU FOR YOUR ASSISTANCE AND WELCOME TO THE FESTIVAL!**

# FESTPAC MEDICAL INTAKE FORM

All questions contained in this questionnaire are **strictly confidential and voluntary** and may become part of your medical record.

Name ( <i>Last, First, M.I.</i> ):		<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
What language do you speak at home?			<input type="checkbox"/> Check box if interpreter is needed	
Where are you staying while on Guam/location:				
School (when assigned):				
EMERGENCY CONTACT INFORMATION				
Name/Address		Relationship to you	Phone Number	Email Address
PERSONAL HEALTH HISTORY				
PREVIOUS OR REFERRING DOCTOR:		DATE OF LAST PHYSICAL EXAM:		
Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio				
Immunizations and dates: <input type="checkbox"/> Tetanus <input type="checkbox"/> Hepatitis <input type="checkbox"/> Influenza				
<i>Please attach a copy of your immunization records.</i> <input type="checkbox"/> Chickenpox <input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i> <input type="checkbox"/> Pneumonia				
WOMEN ONLY				
Are you pregnant?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> First Trimester (1-3 months)	<input type="checkbox"/> Second Trimester (4-6 months) <input type="checkbox"/> Third Trimester (7-9 months)
<i>Please turn to next page</i>				

PROVIDE A COPY OF YOUR MEDICATIONS INCLUDING DOSAGE AND FREQUENCY OR LIST HERE:

LIST ANY ALLERGIES:

PLEASE USE BACK OF FORM IF MORE ROOM IS NEEDED

SURGICAL OR HOSPITALIZATION HISTORY: (List procedure and date)

LIST ANY MEDICAL PROBLEMS THAT MAY BE RELEVANT:

All Disclosures are voluntary and will be kept strictly confidential

Have you ever had a blood transfusion?  YES  NO

What is your blood type?  A + -  B + -  AB + -  O + -  Don't Know

PATIENT MEDICAL HISTORY: (CHECK ALL THAT APPLY)

ASTHMA  CANCER  DIABETES  HEART DISEASE  HIV  
 HEPATITIS  HYPERTENSION  MIGRAINE HEADACHES  STROKE  TUBERCULOSIS

LIST ANY OTHER DISEASES:

FAMILY HISTORY: (CIRCLE STATUS AND CHECK ALL THAT APPLY)

	STATUS	AGE	DIABETES	HYPERTENSION	HEART DISEASE	STROKE	CANCER	MIGRAINE	UNKNOWN
FATHER	ALIVE/DECEASED								
MOTHER	ALIVE/DECEASED								
SIBLING	ALIVE/DECEASED								
CHILDREN	ALIVE/DECEASED								

SOCIAL HISTORY: (COMPLETE AND CHECK ALL THAT APPLY)

Alcohol	Do you drink alcohol?	<input type="checkbox"/> Never	<input type="checkbox"/> Previously but Quit _____	<input type="checkbox"/> Yes # of years _____
	<input type="checkbox"/> # of alcohol/drinks per day	<input type="checkbox"/> # of alcohol/drinks per week	<input type="checkbox"/> # of alcohol/drinks per month	
Tobacco	Do you use tobacco?	<input type="checkbox"/> Never	<input type="checkbox"/> Previously but Quit _____	<input type="checkbox"/> Yes # of years _____
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Betel Nut- #/day
	<input type="checkbox"/> Electronic Cigarettes (VAPORS) - #/day	<input type="checkbox"/> Cigars - #/day	<input type="checkbox"/> Other - #/day	
Drugs	Do you currently use crystal methamphetamine (ice) or other illegal drugs??	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Do you currently use marijuana?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse.			