



אלומה-אמונה

## Medical information

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Medical information that is not complete or not exact can put the patient and the people she will be working with during her national service in danger.

	Does she suffer from this disease*		Has she been hospitalized for this disease*		Time and place of hospitalization
	No	Yes	No	Yes	
Neurological disease (including epilepsy)					
Endocrinology disease					
Hematology disease					
Eye disease, Laser treatment					
Breathing problems (including Asthma)					
Heart disease, Hypertension					
Otolaryngology disease					
Kidney and Urinary disease					
Skin disease					
Joint disease, Skeletal disorders					
Cancer					
GI and liver disease					
Carrier or Tuberculosis					
Psychologist's or Psychiatrist's care					

שירות לאומי. שינוי חייגי.



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	No*	Yes*	Details
Does she take Medications			
Drug Sensitivity			
Allergies			
Did she undergo any special tests			
Did she undergo surgery			

\*Please answer by putting an X in the right place.

Other disease:

\_\_\_\_\_

\*If possible, please include a detailed medical letter, or a copy of a summary of previous hospitalizations, and medical follow up.

**\*Physician statement:** I declare that the information I gave is true to the extent of my knowledge, and I did not hide medical information.

Date: \_\_\_\_\_ Name of Doctor: \_\_\_\_\_

Signature: \_\_\_\_\_ Stamp \_\_\_\_\_

סניף אמוני. סינוי אגוני.

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