



GREEN MOUNTAIN TRIBE INC.

SEC Registration Number: CN201212508
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PERSONAL INFORMATION			
Name			Personal Contact Details
Age	Birth Date	Marital Status	Cellphone:
Gender	Height	Weight	E-Mail:
Present Address			
Permanent Address			
Nationality	Ethnic Background	Religion	
Language/s Spoken			
Skin Color	Hair Color	Eye Color	
Birth Mark/s	Blood Type		
Spouse's Name	Educational Attainment		
Father's Name	Profession/Occupation		
Mother's Name	Employment Status		
Contact Person in case of Emergency			Relationship
Contact Number in case of Emergency			

MEDICAL INFORMATION																																					
PRESENT MEDICAL CONDITION																																					
<div>Do any of these Medical Problem apply to you? Please check box before those that do.</div> <table><tbody><tr><td><input type="checkbox"/> Heart Disease</td><td><input type="checkbox"/> Diabetes</td><td><input type="checkbox"/> Stroke</td><td><input type="checkbox"/> Stomach Ulcers</td></tr><tr><td><input type="checkbox"/> Chest Pain</td><td><input type="checkbox"/> Thyroid Disease</td><td><input type="checkbox"/> Nervous Disorder</td><td><input type="checkbox"/> Heartburn</td></tr><tr><td><input type="checkbox"/> Heart Murmur</td><td><input type="checkbox"/> Arthritis</td><td><input type="checkbox"/> Back Pain</td><td><input type="checkbox"/> Hernia Repairs</td></tr><tr><td><input type="checkbox"/> High Blood Pressure</td><td><input type="checkbox"/> Kidney Stones</td><td><input type="checkbox"/> Blood Transfusion</td><td><input type="checkbox"/> CANCER: List type(s)</td></tr><tr><td><input type="checkbox"/> Shortness of Breath</td><td><input type="checkbox"/> Blood in your Urine</td><td><input type="checkbox"/> HIV or Hepatitis</td><td></td></tr><tr><td><input type="checkbox"/> Asthma/Emphysema</td><td><input type="checkbox"/> Frequent Urination</td><td><input type="checkbox"/> Bleeding Tendency</td><td></td></tr><tr><td><input type="checkbox"/> Blood with Coughing</td><td><input type="checkbox"/> Pain with Urination</td><td><input type="checkbox"/> Diarrhea</td><td><input type="checkbox"/> Others:</td></tr><tr><td><input type="checkbox"/> Anesthetic Reaction</td><td><input type="checkbox"/> Depression</td><td><input type="checkbox"/> Constipation</td><td></td></tr></tbody></table>						<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Nervous Disorder	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Hernia Repairs	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> CANCER: List type(s)	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Blood in your Urine	<input type="checkbox"/> HIV or Hepatitis		<input type="checkbox"/> Asthma/Emphysema	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Bleeding Tendency		<input type="checkbox"/> Blood with Coughing	<input type="checkbox"/> Pain with Urination	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Others:	<input type="checkbox"/> Anesthetic Reaction	<input type="checkbox"/> Depression	<input type="checkbox"/> Constipation	
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Elaborate Medical Problem																																					
List all previous surgeries																																					
List all known Allergies																																					
MEDICATION/S (Maintenance and/or Emergency)																																					
Medicine/Drug Name	Strength	Amount	Route	Frequency	Maintenance or Emergency																																
FAMILY MEDICAL HISTORY																																					
Kindly check the box if applicable to your family medical history, if none leave it blank. Legends: M-Maternal side, F-Fraternal Side and B-Both mother and father side																																					
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1	Heart Disease				16	Depression																															
2	Chest Pain				17	Stroke																															
3	Heart Murmur				18	Nervous Disorder																															
4	High Blood Pressure				19	Back Pain																															
5	Shortness of Breath				20	Blood Transfusion																															
6	Asthma/Emphysema				21	HIV or Hepatitis																															
7	Blood with Coughing				22	Bleeding Tendency																															
8	Anesthetic Reaction				23	Diarrhea																															
9	Diabetes				24	Constipation																															
10	Thyroid Disease				25	Stomach Ulcers																															
11	Arthritis				26	Heartburn																															
12	Kidney Stones				27	Hernia Repairs																															
13	Blood in your Urine				28	CANCER: List type(s)																															
14	Frequent Urination				29	Others:																															
15	Pain with Urination																																				

I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately.

Applicant's Signature over Printed Name, Date Signed

Date Signed: _____