



976 Tee Court, Incline Village, NV 89451 ▲ Tel: (800) 670- 6984 or (775) 832-5454 ▲ Fax: (775) 832-4454
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MEDICAL FORM

Trip Title _____ Trip Date _____
 Business Phone _____ Home Phone _____
 Name _____ Sex ___ Age _____ Height _____ Weight _____
 Previous MM Treks _____

MM TREK BACKGROUND INFORMATION FOR PHYSICIAN AND APPLICANT

Myths and Mountains, Inc. (MM) operates its treks in a variety of conditions, some in isolated wilderness areas. Occasionally, an MM trek can be days from modern medical facilities. Trips vary in length from two weeks to four weeks. Depending on the specific type of trek, the applicant may be carrying a pack of 5-35 pounds at altitudes up to 20,000 feet. Participants will often sleep outdoors, and are expected to take care of themselves. Weather conditions can be extreme, with temperatures ranging from -5 degrees F. to +80 degrees F. Prolonged storms, high winds, and/or intense sunlight are possible. MM treks can be physically demanding. Prior physical conditioning is strongly recommended.

In the interest of the personal safety of both the applicant and the other trek members, please consider the above description carefully when completing the Medical Form. A “YES” answer does not necessarily cancel an applicant’s enrollment, but we do need the information. The physician completing this form may *not* be a relative of the applicant.

APPLICANT: The following medical information as completed by the physician is complete and true to the best of my knowledge. I recognize that falsification or omission of information is grounds for my removal from the trek.

Applicant Signature: _____ Date: _____

PHYSICIAN: Please circle YES or NO for each item and provide details on EVERY “YES” answer in the explanation section that follows.

Does the applicant have currently or does he/she have a history of:

- | | |
|---|------------|
| 1. Knee, ankle, back, or any other joint problems including sprains, injuries or operations? (what and when?) | 1. YES NO |
| 2. Respiratory problems? | 2. YES NO |
| 3. Gastrointestinal disturbances? | 3. YES NO |
| 4. Eating disorders? | 4. YES NO |
| 5. Disorders of the urinary tract? | 5. YES NO |
| 6. Hypertension? | 6. YES NO |
| 7. Liver dysfunction? | 7. YES NO |
| 8. Arthritis? | 8. YES NO |
| 9. Neurological problems? | 9. YES NO |
| 10. Epilepsy or seizures? | 10. YES NO |
| 11. Treatment or medication for abdominal cramps?
Menstrual cramps? Please specify. | 11. YES NO |

(over)

- | | |
|--|------------|
| 12. Treatment or problems associated with drug/
alcohol/chemical abuse or dependency? | 12. YES NO |
| 13. Psychiatric/psychological treatment or
counseling? | 13. YES NO |
| 14. Thyroid problems? | 14. YES NO |
| 15. Cardiac problems? | 15. YES NO |
| 16. Physical disability? | 16. YES NO |
| 17. Is s/he a diabetic? | 17. YES NO |
| 18. Has s/he ever had frostbite? Describe
symptoms and treatment. | 18. YES NO |
| 19. Has s/he ever had symptoms of Acute
Mountain Sickness? | 19. YES NO |
| 20. Any other disease? | 20. YES NO |
| 21. Is s/he allergic to any medications such as
sulfa or antibiotics? Be specific. | 21. YES NO |
| 22. Is s/he allergic to any foods, insects,
plants, etc. Please specify. | 22. YES NO |
| 23. Is s/he currently taking any medications?
Please specify dose. | 23. YES NO |
| 24. Is s/he on a medically prescribed diet? | 24. YES NO |
| 25. Does the person see a specialist of any kind? | 25. YES NO |
| 26. Is there any additional information we
would want to know? | 26. YES NO |

PHYSICIAN'S EXPLANATION OF ALL "YES" ANSWERS – BE SPECIFIC

PHYSICAL EXAMINATION (Please type or print legibly) Applicants over 60 years of age and applicants over 40 years of age with a history of cardiovascular disease, obesity, or high blood pressure are required to have a stress electrocardiogram. We also recommend this for individuals with a sedentary lifestyle or those without frequent physical exercise (three times weekly).

1. Blood Pressure: _____ Pulse: _____ Last DT series _____
2. General Appearance: _____
3. Physical Examination: _____
4. General Impressions: _____
5. On the basis of the background information at the beginning of this form and your examination, do you feel that this individual can participate in this MM trek? (Circle One) **YES NO**

Comments: _____

NAME: _____ M.D.
 ADDRESS: _____
 PHONE: (____) _____
 PHYSICIAN'S SIGNATURE: _____ DATE: _____

PLEASE RETURN TO: Myths and Mountains, Inc.
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