

# MEDICAL HISTORY FORM

(PLEASE PRINT)

Last Name	First Name	Middle Name	Student ID #
Date of Birth	Sex/Gender	Country of Birth	
Permanent Address	City	State	Zip Code
Local Address	City	State	Zip Code
( )	( )		
Telephone	Cell Phone		
<input type="checkbox"/> O.K. to leave message with detailed information		<input type="checkbox"/> Leave message with call-back number <u>only</u>	
Check One: <input type="checkbox"/> African American <input type="checkbox"/> East Indian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Other			
<b>Emergency Contact:</b>			
Name	Relationship	( )	( )
		Telephone	Cell Phone
Address	City	State	Zip Code

HAVE YOU HAD:	YES	NO	HAVE YOU HAD:	YES	NO	HAVE YOU HAD:	YES	NO
Head Injury with Unconsciousness			Sexually Transmitted Disease			Counseling/Mental Health Treatment		
Recurrent Headaches			Gynecology Problem(s)			Tobacco Use		
Seizure Disorder			Digestive Tract Problem			Recreational Drug Use		
Spinal Cord Disruption			Eating Disorder			Alcohol Use		
Heart Problem/Murmur			Recent Weight Gain/Loss			Alternative Medicine Products:		
High Blood Pressure			Thyroid Problem					
High Cholesterol			Diabetes					
Bleeding/Blood Disorder			Asthma			Chronic Health Problems:		
Rheumatic Fever			Hay Fever					
Scarlet Fever			Tuberculosis					
Cancer/Tumor/Cyst			Malaria			Surgery/Dates:		
Recurrent Ear Infections			Chicken Pox					
Hearing Loss			Hepatitis A, B, or C					
Visual Problem (other than glasses)			Kidney or Urinary Tract Problem					

If you checked YES to any of the above, please describe in detail on the reverse side.

Drug Medication Allergies: (write NONE if none)	Other Allergies: (write NONE if none)	Routine Medications Taken: (write NONE if none)
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**CONTINUED ON REVERSE SIDE**

# MEDICAL HISTORY FORM

(continued from reverse side)

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\_\_\_\_\_  
 Last Name                                      First Name                                      Middle Name

Family Member	Occupation	Health Status Excellent/Average/Poor	Age	If no longer living, Cause of Death & Age at Death
Father				
Mother				
Brothers				
Sisters				
Spouse/Partner				
Children				

**HAS ANY FAMILY MEMBER (parent, sibling, or grandparent) EVER HAD:**

	YES	NO	Relationship		YES	NO	Relationship
Tuberculosis				Asthma			
Drug/Alcohol Abuse				Thyroid Disease			
Diabetes				Seizure Disorder			
Kidney Disease				Blood Disorder			
Heart Disease				Cancer			
High Blood Pressure				Stroke			
Arthritis				Obesity			
Stomach Disease				Other			
High Cholesterol							

**FURTHER INFORMATION ON MEDICAL CONDITION/CONCERNS:**

\_\_\_\_\_  
 Student Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Parent Signature if student is a minor

\_\_\_\_\_  
 Date