



MEDICAL HISTORY REPORT

Please complete both sides of this form before visiting your physician for examination

Last Name	First Name	Middle	Gender (circle) M / F		
Home Address (number and street)	City	State	Zip	Date of Birth	
Name, Relationship, and Address of Closest Relative				Phone	
Relative's Business Address				Business Phone	

List colleges you have attended (include addresses and dates)

Are you a veteran? Yes No If yes: Branch _____ Length of Service _____ Marital Status: Single Married Other

Class you are entering: Freshman Sophomore Junior Senior

Family History					
	Age	State of Health	Occupation	Age of Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Have any of your relatives had any of the following?			
	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Arthritis			
Stomach Disease			
Asthma, Hay Fever			
Epilepsy, Convulsions			

Personal History											
Please answer all questions. Comment on all positive answers in the space provided on reverse side or on additional paper.											
Have you had:	Yes	No	Have you had:	Yes	No	Have you had:	Yes	No	Have you had:	Yes	No
Chicken Pox			Frequent Depression			Pain/Pressure in Chest			Gallbladder Trouble or Gallstones		
Measles			Worry or Nervousness			Chronic Cough			Recurrent Diarrhea		
German Measles			Recurrent Headache			Palpitations (heart)			Rupture, Hernia		
Mumps			Recurrent Colds			High/Low Blood Pressure			Recent Gain/Loss of Weight		
Scarlet Fever			Seizure Disorders			Rheumatic Fever or Heart Murmur			Dizziness, Fainting		
Malaria			Diabetes			Disease or Injury of joints			Weakness, Paralysis		
Gum or Tooth Trouble			Mono			"Trick" Knee, shoulder, etc.			Venereal Disease		
Sinusitis			Head Injury with Unconsciousness			Back Problems			Albumin/Sugar in Urine		
Eye Trouble			Hay Fever, Asthma			Tumor, Cancer, Cyst					
Ear, Nose, Throat Trouble			Tuberculosis			Jaundice			Females only:		
Surgery			Shortness of Breath			Stomach or Intestinal Trouble			Irregular Periods		
Appendectomy			Pneumonia			Eating Disorder			Severe Cramps		
Tonsillectomy			Allergy						Excessive Flow		
Hernia Repair											
Other			Penicillin								
			Sulfonamides								
Insomnia			Serum								
Frequent Anxiety			Foods (which)								
Emotional Disorder			Other								

- A. Has your physical activity been restricted during the past 5 years? (Give reasons and durations.)
 Yes No

- B. Have you had difficulty with school, studies, or teacher? (Give details) Yes No

- C. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? (Give details) Yes No Please list all medications taken for this condition.

- D. Have you had any illness or injury or been hospitalized other than already noted? (Give details)
 Yes No

- E. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years? (other than routine checkups?) Yes No

- F. Have you been rejected or discharged from military service because of physical, emotional, or other reasons? (Give reasons) Yes No

- G. Do you have any question regarding your health, family history, or other matters, such as pre-marital counseling, which you would like to discuss now with a staff member of Health Services? Yes No

- H. Are you taking any medicine or drugs? Yes No

- I. Do you have any dietary problems necessitating special diets? Yes No

Remarks or additional information:

By signing this document, I agree that I have disclosed all information concerning physical and/or psychological conditions for which I have been diagnosed or treated.

_____ Student Signature	Date _____
_____ Physician's Signature (Acknowledging Review)	Date _____