Medical History Form

Date ____ / ____ / ____

Student Name _____ Social Security # _____ - _____ - _____

Home Phone (____) ____ - _____ Date of Birth _____ / _____ / _____

Address _____

Street City State Zip

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐

Hospitalization or Surgery

Reason	Date	Reason	Date

Women Only: Pregnant? ☐Yes ☐No Previous Pregnancy? ☐Yes ☐No

Medical History

☐ADHD
☐Allergies/Hay Fever
☐Anemia
☐Arthritis
☐Asthma
☐Bowel Irregularity
☐Bronchitis
☐Chest Pain
☐Chronic Rashes
☐Depression
☐Diphtheria
☐Dizziness/Fainting
☐Frequent infections
☐Gallbladder disease
☐GI disorder
☐Headache
☐Heart Murmur
☐Heart palpitations
☐Hepatitis
☐Incontinence
☐Lactose Intolerance
☐Measles
☐Meningitis
☐Mumps
☐Nervousness
☐Polio
☐Osteoporosis
☐Peripheral Vascular Disease
☐Pneumonia
☐Rheumatic fever
☐Rubella
☐Scarlet Fever
☐Sexual / Menstrual dysfunction
☐Shortness of breath
☐Tetanus
☐Ulcer
☐Venereal disease
☐Other_____
☐Other_____

☐ **Limits to strenuous activity?** Explain _____

Habits

☐Exercise Routine: _____
_____
_____

☐Sleep:
❑Difficulty falling asleep
❑Continuity disturbances
❑Snoring
❑Early morning awakening
❑Daytime drowsiness
❑Other _____

Hepatitis C risk factor

☐Blood transfusion prior to 1992
☐IV drug use (1 + times)
☐Contact with blood/bodily fluid
☐Tattoos
☐Shared razor/toothbrush
☐Body piercing