



# Part B: Report of Medical History

NAME, RELATIONSHIP AND ADDRESS OF NEXT OF KIN

HOME TELEPHONE NUMBER

## FAMILY HISTORY

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brother					
Sister					

Have any of your relatives ever had any of the following?

	Yes	No
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Death	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy, Convulsion	<input type="checkbox"/>	<input type="checkbox"/>

## PERSONAL HISTORY PLEASE ANSWER ALL QUESTIONS

Write comment on all positive answers on the back side of this sheet.

HAVE YOU HAD?	Yes	No		Yes	No		Yes	No	Yes	No	
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Trouble/Gallstones	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Pain/ Pressure in Chest	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Cancer, Cysts	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations(Heart)	<input type="checkbox"/>	<input type="checkbox"/>	Rupture, Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Worry/Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Colds	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness, Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Stomachitis	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	Weakness, Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Eye Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Ear, Nose, Throat Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	<input type="checkbox"/>
Veneral Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or Intestinal Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy, Convulsion	<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury with Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	Recent Gain or Loss of Weight	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Depression	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
"Trick" Knee, Shoulder etc.	<input type="checkbox"/>	<input type="checkbox"/>				Gum or Tooth Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Disease or Injury of Joints etc.	<input type="checkbox"/>	<input type="checkbox"/>
						Albumin/Sugar in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever or Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>

## SURGERY

Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>
Hernia Repair	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

## ALLERGY

Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Sulfonamides	<input type="checkbox"/>	<input type="checkbox"/>
Foods (which)	<input type="checkbox"/>	<input type="checkbox"/>
Serum	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

## FEMALES ONLY

Excessive Flow	<input type="checkbox"/>	<input type="checkbox"/>
Severe Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Period	<input type="checkbox"/>	<input type="checkbox"/>

- A. Has your physical activity been restricted during the past five years? (Give reasons and durations)
- B. Have you had difficulty with school studies, or teachers (Give details)
- C. Have you received treatment or counseling for a nervous condition, personality of character disorder, or emotional problems? (Give details)
- D. Have you had any illness or injury or been hospitalized other than already noted? (Give details)
- E. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (Give details)
- F. Have you been rejected for or discharged from military service because of physical, emotional, or other reason? (Give details)
- G. Do you regularly take medication? If so, list (Include tranquilizers)
- H. Do you have any questions in regard to your health, family history, or other matters, such as premarital counseling which you would like to discuss now with a member of the staff of the Health Services?

Yes No

## IMMUNIZATION TESTS

## IMPORTANT RECORDS

## MANDATORY

COMPLETED

Yes No Date of last immunization

Tetanus-Diphtheria Toxoid	<input type="checkbox"/>	<input type="checkbox"/>	
Booster within last 10 Yrs	<input type="checkbox"/>	<input type="checkbox"/>	
Smallpox	<input type="checkbox"/>	<input type="checkbox"/>	
Polio Type:	<input type="checkbox"/>	<input type="checkbox"/>	
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	
Measles	<input type="checkbox"/>	<input type="checkbox"/>	
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculin Skin Test			
within last 1 Yr. Date: _____	Positive _____	Negative _____	
If positive, Chest X-Ray Required - Date _____			
Chemoprophylaxis	Report _____		
Date Initiated: _____			
Date: _____			

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

Date: \_\_\_\_\_