CONFIDENTIAL Date_____

MEDICAL HISTORY FORM

Name _____ Birthdate _____

Do you: Smoke?_____ Packs per day_____ # Years smoked_____
Drink Alcohol?_____ Drinks per day_____
Drink cola/coffee?_____ How much per day?_____

List the medications you are now taking:

_____ _____ _____

List any allergies you have to drugs, food or other items:

_____ _____ _____

Are you currently under medical care for any reasons? If yes, please explain:

WOMEN ONLY:

Age when menstrual periods began _____
Are your periods regular? _____ How often?_____
How many days do your periods last? _____
How many times have you been pregnant? _____
How many children born alive? _____

Primary Care Physician: Name: _____
Address and City: _____
Phone: _____

Past Psychiatric/Mental Health Care:

Provider's Name: _____ For How long?_____
When:_____

List All Operations:

Operation Performed	Year	Hospital	Doctor
_____	_____	_____	_____
_____	_____	_____	_____

List all times you have been admitted to a hospital for an emergency/observation (except for childbirth)

_____	_____	_____	_____
_____	_____	_____	_____

Please check if any relative (parents, siblings, grandparents, children) have had any of the conditions listed below:

High blood pressure: _____	Kidney Disease: _____	Asthma: _____
Stroke: _____	Bleeding Tendencies: _____	Tuberculosis: _____
Cancer: _____	Seizures: _____	Colitis: _____
Emphysema: _____	Heart Disease: _____	Anemia: _____
Ulcers: _____	Sugar Diabetes: _____	Gout: _____
Mental Illness: _____	Other Serious Illness: _____	

Have you had any of the following illnesses: (Please Circle)

Measles	Diabetes	Typhoid
Rubella (German Measles)	Goiter, Thyroid Disease	Malaria
Chickenpox	Hives	Other Tropical Diseases
Mumps	Allergies	Hepatitis
Whooping Cough	Eczema	Venereal Disease
Scarlet Fever	Mono	Seizures
Tonsillitis	Rheumatic Fever	Meningitis
Diphtheria	Poliomyelitis	Ear Infections
Asthma	Pleurisy	Heart Murmur
Glaucoma	Bronchitis	High Blood Pressure
Cancer	Influenza	Low Blood Pressure
Angina Pectoris	Tuberculosis	Heart Attack
Ulcer	Phlebitis	Kidney Stones
Bladder or Kidney Infection		

Other serious illnesses: (Please Explain):

Please list the date and results (if known) of your last:

X-ray_____

EKG:_____

Blood Count:_____

Date of last examination by a doctor:_____

It should be noted that medications may have unwanted side effects. You are strongly urged to bring to our attention any problem that you may be having with your medications.

_____ _____

Student Signature Date

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