Deadline: June 24

Medical History Report

To be completed by student and signed by health care provider.
Please complete prior to visiting your health care provider for physical examination.

Student Name______________________________ Date of Birth______________

Family History

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

Have any of your relatives ever had any of the following:	YES	Relationship
Alcohol/substance abuse		
Cancer		
Tuberculosis		
Diabetes		
Kidney Disease		
Stomach Disease		
Asthma, Hay Fever		
Seizure Disorder		

Personal History: Please answer all questions.

Have you had:

	Yes	No		Yes	No		Yes	No		Yes	No
Anemia			Dizziness/Fainting			Kidney Disease/Stones			Sexually Transmitted Infections		
Anxiety			Ear/Nose/Throat Trouble			Learning Disability/ADD/ADHD			Sickle Cell Disease		
Appendectomy			Eye Trouble			Loss of Paired Organ			Sports Injuries		
Arthritis			Gallbladder Trouble			Malaria			Stomach/Intestinal Trouble		
Asthma			Gum/Tooth Trouble			Measles			Tuberculosis Disease		
Back Problems			Hay Fever			Measles (German)			Ulcer/Stomach Problem		
Bipolar Disorder			Head Injury with unconsciousness			Migraines			Urinary Infection		
Blind/Visual Impairment			Headache (recurrent)			Mononucleosis			UTI's (frequent/recurrent)		
Cancer			Heart Disease			Mumps			Other (please list):		
Chicken Pox			Heart Palpitations			Neuromuscular Disease					
Concussion			Hepatitis			Pain/Pressure in Chest					
Chronic Cough			Hernia/Rupture			Pneumothorax					
Colds (recurrent)			High/Low Blood Pressure			Phlebitis/Deep Vein Clot			**FEMALES ONLY**		
Crohn's/Colitis/IBS			High Cholesterol			Recent Weight Gain/Loss			Irregular Periods		
Deaf/Hearing Impaired			HIV Infection			Rheumatic Fever/Heart Murmur			Severe Cramps		
Depression			Impaired Mobility/Paralysis			Scarlet Fever			Excess Flow		
Diarrhea (recurrent)			Jaundice			Seizure Disorder			Pregnancy		

PLEASE EXPLAIN ALL POSITIVE ANSWERS (with dates – attach additional sheet if needed):

____

____

____

____

CONTINUE TO BACK

Inpatient Hospitalizations: Please list all medical and/or psychiatric hospitalizations with dates/diagnoses:

____

____

Allergies to medications: _____No known allergies _____Yes

If yes, please specify____

Winslow Health Center may share select information from this form with the Counseling and Personal Development Center as deemed necessary by the Director of WHC unless the student requests in writing to WHC that this information not be shared.

____

Student Signature Date

____

Health Care Provider Signature (Acknowledging Review)

Medications: Please list details of all current medications.

____

____

____