LOYOLA UNIVERSITY MEDICAL CENTER ♦ EMT-PARAMEDIC PROGRAM

2011
STUDENT HEALTH FORM

Last name	First name	Social Security Number	
Home address	City	State	Zip
Home phone	Date of Birth	Age	❑ Male ❑ Female
In case of emergency notify (name)		Relationship	
Address		Home phone	Work phone
Health insurance carrier (attach copy of insurance card)		Phone	Group plan #
Personal physician	Address		Phone

HOSPITALIZATIONS: Reason and Date
1)
2)
3)

SOCIAL HISTORY			
	Yes	No	
Tobacco Use			
Alcohol Use			
History of treatment if yes			
Drug Use			
History of treatment if yes			

PERSONAL HISTORY: Please comment on all yes answers in the space below or on an additional sheet

Have you had?	Yes	No		Yes	No		Yes	No		Yes	No
Allergies, seasonal			Depression			Headache, recurrent			Sinusitis		
Anemia			Diabetes			Heart Condition/Murmur			Stomach Disorder		
Anxiety/Panic attacks			Dizziness/Fainting			Hepatitis			Strep Throat, recurrent		
Asthma, chronic			Ear, nose, throat, Disorder			High Blood Pressure			Surgery		
Asthma, exercise induced			Eating Disorder			HIV/AIDS			Appendectomy		
Back Problem			Epilepsy			Kidney Infection/Stone			Tonsillectomy		
Bronchitis, recurrent			Eye Problem			Menstrual Problems			Other		
Cancer/Tumor/Cyst			Fracture/Sprain			Mononucleosis			Thyroid Disorder		
Chicken Pox			Gallbladder Disease			Pneumonia			Tuberculosis		
Counseling			Head Injury			Rheumatic Fever			Weight Gain/Loss, recent		

List medications (any used on a regular basis):
List allergies to drugs, foods, pollen, molds, other:
List any illness or injury other than already noted:
List any physical limitations or restrictions:

COMMENTS

SIGNATURE	**DATE**