2010
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**