



2010  
STUDENT HEALTH FORM

Last name	First name	Social Security Number	
Home address	City	State	Zip
Home phone	Date of Birth	Age	<input type="checkbox"/> Male <input type="checkbox"/> 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	SOCIAL HISTORY		
1)		Yes	No
2)	Tobacco Use		
	Alcohol Use		
3)	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):	<b>COMMENTS</b>
List allergies to drugs, foods, pollen, molds, other:	<b>COMMENTS</b>
List any illness or injury other than already noted:	<b>COMMENTS</b>
List any physical limitations or restrictions:	<b>COMMENTS</b>

<b>SIGNATURE</b>	<b>DATE</b>
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