STUDENT HEALTH HISTORY FORM

Please complete this form before going to your Physician for examination.

STUDENT NAME	DATE OF BIRTH

PERSONAL HISTORY Have you ever had or have now (check all that apply)

	Anemia		Depression		HIV Infection/Disease		Pneumothorax
	Anxiety		Diabetes		Kidney Stones/Disease		Seizure Disorder
	Anorexia/Bulemia		Dizziness/Fainting Spells		Learning Disabilities		Sickle Cell Amemia
	Arthritis		Emotional/Mental Health Illness		Meningitis Bacterial/Viral		STD's
	Asthma		Frequent Ear Infections		Menstrual Problems		Substance Abuse Problems
	Bronchitis		Heart Disease/Problems/Murmers		Migraines/Chronic Headaches		Thyroid Disease
	Back Problems		Hepatitis (TYPE:)		Mononucleosis		TB/Tuberculosis
	Cancer		Head Injury/Concussion		Neuromuscular Disease		Ulcer/Stomach Problems
	Chicken Pox		High Blood Pressure		Nose Bleeds		UTI's Freguent/Recurrent
	Crohn's/Colitis/IBS		High Cholesterol		Phlebitis/Deep Vein Blood Clot		Vision/Hearing Problems
	OTHER:						

EXPLAIN ALL CHECKED ANSWERS

ARE YOU CURRENTLY UNDER A PHYSICIANS CARE? EXPLAIN

What medications are you taking and for what reason?

HAVE YOU EVER BEEN OR ARE CURRENTLY IN COUNSELING? EXPLAIN

What medications are you taking and for what reason?

Name of prescriber of medication

HOSPITALIZATIONS Please list all hospitalizations including dates, diagnosis and surgeries

INJURIES Include accidents, broken bones, sprains, sports related injuries with dates and treatment received if any

LIST CURRENT MEDICATIONS

ALLERGIES

IF YOU HAVE ASTHMA DO YOU HAVE AN INHALER? YES/NO
WHAT IS YOUR BEST PEAK FLOW?

DO YOU HAVE AN EPI PEN? YES/NO

FAMILY HISTORY

Has anyone in your immediate family had any of the following?	Yes	No	Relationship
Alcoholism			
Asthma			
Bleeding disorders			
Epilepsy/Seizures			
Emotional Disorders			
Heart Attack			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Stroke			
Breast Cancer			
Other Cancer			
Other			
Depression/Anxiety/Panic Disorder			
Other			

I have answered these questions to the best of my knowledge.

STUDENT SIGNATURE X______________________________

LIFESTYLE

1. Alcohol (Drinks per week)?______________________
2. Cigarettes per day?__________Years smoked?____________
3. Do you diet frequently?______________________________
4. Do you exercise regularly (days per week)?______________
5. Do you or have you ever used recreational drugs? Yes/No
   What type?
6. Do you or have you ever used prescriptions medications for recreational use? Yes/No
   What type?

ALL INFORMATION PROVIDED IS CONFIDENTIAL

PROGRAMS INTERESTED IN ATTENDING

1. Exercise Classes (circle all that apply)
   Yoga Pilates Step Classes Muscle Mix Kickboxing Other________
2. Stop smoking program? Yes No
3. Substance abuse program? Yes No
4. Stress reduction classes? Yes No
5. Weight loss program? Yes No
6. Nutrition program? Yes No
7. Heart health class? Yes No
8. Anger management? Yes No
9. Other____