STUDENT RECORD OF HEALTH HISTORY

_____ ____/____/____ Male Female

LAST NAME (Please Print) FIRST NAME MI (DATE OF BIRTH) (PLEASE CIRCLE)

Have you ever had an allergic reaction to, or been told NOT to take certain medications? (Please Circle) No Yes

If you answered "yes", please list all medications you are allergic to:_____

Do you have allergies to environment (i.e., hay fever), foods, insect stings, etc.? (Please Circle) Yes No

If you answered "yes", please list what you are allergic to: _____

Please list ALL medications you are now taking and the reason for the medication (including OTC medications, medications for ADD/ADHD, depression, anxiety, bipolar disorder, birth control pills, allergy serum, etc.) PLEASE PRINT CLEARLY

Name of Medication	Reason for Medication	Dosage	How Often

Please list any surgeries or hospitalizations you have had: **PLEASE PRINT CLEARLY**

Surgery	Date	Surgery	Date

Have any of your immediate family (parents, grandparents, siblings) ever had any of the following:

Condition	Y	N	Relationship	Condition	Y	N	Relationship
Asthma				High Blood Pressure			
Cancer				Kidney Disease			
Diabetes				Seizure Disorders			
Heart Attack <age 50				Thyroid Disease			
Heart Disease				Other			

Do YOU have a present or past history of the following:

Condition	Y	N	Condition	Y	N	Condition	Y	N	Condition	Y	N
ADD/ADHD			Convulsions/seizures			Hernia/rupture			Mitral valve prolapse		
Alcoholism/Drug Abuse			Cystic Fibrosis			High Blood Pressure			Pacemaker		
Anemia			Depression			HIV			Pneumonia		
Anxiety			Diabetes			Intestinal problems/Colitis			Sickle Cell disease/trait		
Asthma			Do you Smoke?			Irritable Bowel			Skin conditions		
Bipolar			Epilepsy			Joint Disease			STD's		
Bleeding (abnormal)			Hay Fever			Kidney Disease			Suicide Attempt		
Cancer/impaired immunity			Head injury/unconsciousness			Leukemia			Thyroid disorder		
Cerebral Palsy			Hearing loss			Liver Disorders			Ulcer/stomach or other		
Cholesterol problems			Heart disease			Low blood pressure			Other		
Concussions			Heart murmurs			Migraines					

If you answered "yes" to anything above, please give explanations on the reverse side of this form.

FEMALES ONLY:	Yes	No	MALES ONLY:	Yes	No
Date of last GYN exam: / /			Testicular lump		
Irregular periods (missed)			Scrotal lump		
Severe cramps			Breast changes		
Abnormal pap smear			Regular testicular self-exams?		
Cystic breast/breast changes					

If you are currently being treated by a psychiatrist or other mental health professional, counselor, psychologist, etc., please complete this section:

Name:_____ Phone:_____

Name:_____ Phone:_____