TO BE COMPLETED BY ALL STUDENTS

STUDENT NAME:_____

1. ILLNESSES: Check the ☐ if you have had any of the following.
Check the ○ if a **close blood relative** has had any of the following.

☐○	alcoholism	☐○	lung disease	☐○	high blood pressure
☐○	anemia	☐○	epilepsy, seizures	☐○	ulcer in stomach/duodenum
☐○	asthma	☐○	stroke	☐○	psychological disorder
☐○	bleeds easily	☐○	heart disease	☐○	nervous breakdown
☐○	drug abuse	☐○	suicide attempt	☐	mumps, measles, chicken pox
☐○	depression	☐○	diabetes	☐	rheumatic fever
☐○	hives	☐	thyroid disease	☐	polio
☐	liver disease, hepatitis	☐	venereal disease	☐	malaria
☐	yellow jaundice	☐○	cancer, tumor		

If anyone in your family has had any of the above illnesses, please list the relationship to you and describe the extent of the illness:

_____

_____

_____

2. HOSPITALIZATIONS/SURGERY: List major operations and injuries with the approximate year. Please include all pregnancies.

_____ _____

_____ _____

3. MEDICINES YOU ARE TAKING: List medicines, birth control pills or vitamins you take with or without a prescription. If asthmatic, list any MDIs you take and precipitants (i.e. what brings on your attack).

_____ _____ _____

_____ _____ _____

_____ _____ _____

4. MEDICINE and/or FOOD ALLERGIES: List those to which you are allergic.

_____ _____ _____

_____ _____ _____

5. IMMUNIZATIONS Check those you have had. Note most recent year received.

☐ Flu _____ ☐ Tetanus/Diphtheria _____ ☐ Varicella (or antibody) _____

☐ Polio _____ ☐ M.M.R. _____ ☐ Hepatitis B _____ ☐ Meningococcal _____

The information contained in this form will be held in strictest confidence!