*Students Name _____

Personal Health History

*Date of Birth ____/____/_____

Have you had or do you have any of the following:

	NO	YES		NO	YES		NO	YES	
1.	( )	( )	Vision Difficulty, Eye Disorders	( )	( )	Blood Clotting Disorder	( )	( )	MRSA
2.	( )	( )	Ear Trouble/ Hearing difficulty	( )	( )	Anemia	( )	( )	Cancer
3.	( )	( )	Seasonal Allergies	( )	( )	Diabetes	( )	( )	Rheumatoid Arthritis
4.	( )	( )	Chronic Sinusitis	( )	( )	Constipation	( )	( )	Broken Bones
5.	( )	( )	Thyroid Disorders	( )	( )	Stomach Ulcers	( )	( )	Sprains /Dislocations
6.	( )	( )	Repeated Ear Infections	( )	( )	Chronic Diarrhea	( )	( )	Concussion
7.	( )	( )	Pneumonia	( )	( )	Ulcerative Colitis/Crohn's	( )	( )	Back problems
8.	( )	( )	Mono	( )	( )	Liver Disease/Hepatitis	( )	( )	Fainting episodes
9.	( )	( )	Asthma	( )	( )	Kidney Disorders	( )	( )	Seizure disorder
10.	( )	( )	Irregular Heart Beat	( )	( )	Bladder Infections	( )	( )	Migraine headaches
11.	( )	( )	Congenital Heart Defect	( )	( )	Pelvic Infection/Pain	( )	( )	Other physical disorders
12.	( )	( )	Heart Murmur	( )	( )	Irregular Menstrual	( )	( )	Alcoholism
13.	( )	( )	Rheumatic Heart Disease	( )	( )	Hernia	( )	( )	Drug dependency
14.	( )	( )	Heart Disease (under age 50)	( )	( )	Pilonidal Sinus/Cyst	( )	( )	Depression
15.	( )	( )	High Blood Pressure	( )	( )	Skin Disorders: (Please Circle)	( )	( )	Anxiety
16.	( )	( )	Repeated Strep Infections			Eczema/Psoriasis/ Severe Acne/	( )	( )	Eating Disorder
17.	( )	( )	Tooth /Gum Disease			Other _____	( )	( )	Other Psychological
18.	( )	( )	Stroke	( )	( )	Autism Spectrum Disorder			

Do you have ALLERGIES to any of the following:

NO YES

56. ( ) ( ) Allergies to Medications: Please list name of medications and type of reaction :

_____

_____

57. ( ) ( ) Environmental allergies : Please list

_____

_____

58. ( ) ( ) Food allergies– Please list:

_____

59. ( ) ( ) Chemical or contact substances:

_____

60. ( ) ( ) Others– Please list:

_____

NO YES

61. ( ) ( ) Are you currently taking any prescribed medication on a regular or intermittent basis?

Name of medication and dosage:_____

Condition for which it is prescribed;_____

_____

62. ( ) ( ) Have you ever been hospitalized for an illness or injury?

Date/Year ____/____/_____

Reason for hospitalization _____

63. ( ) ( ) *Do you have any chronic health problem which require regular treatment?

64. ( ) ( ) *Do you have a physical handicap or a learning disability with which we can assist you?

*If yes, contact, *The Teaching and Learning Center* in Doyle Hall, Phone: 716-375– 2066.)

Please give a significant explanation of ***all*** of the above items to which you have answered **YES.**

_____

_____

_____

_____

_____

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