SoutheastHEALTH
College of Nursing & Health Sciences

Program: _________

Medical History Form

This information is confidential and will be used as an aid in providing necessary health care while you are a student. Please return this form with your application. Health information is only reviewed after the admission committee recommends an applicant be admitted.

____
First Name　　Middle Name　　Last/Family Name　　Previous Names (if applicable)

___________________________　　___________________________　　Circle one: Male Female
Social Security Number　　Date of Birth (mm/dd/yyyy)

____
Address　　City　　State　　Zip　　County

____________________　　____________________　　____________________　　____________________
Home Phone　　Cell Phone　　Work Phone　　Email address

Emergency Contact: ____
Full Name　　Relationship

____
Address　　City　　State　　Zip　　County

____________________　　____________________　　____________________
Home Phone　　Cell Phone　　Work Phone

Family Physician: ____
Full Name　　Phone Number

____
Address　　City　　State　　Zip　　County

Insurance: ____
Medical Insurance Company　　Policy Number　　Group Number

The College strongly urges every student to subscribe to an insurance plan which provides comprehensive medical, surgical treatment, and accidental care.

Immunization History: The Missouri Division of Health is requesting we have a documented record of a student's immunizations. Please include a copy of your immunization records: from your baby book, public health record, high school records, or a copy of your doctor's records. These include measles, mumps, and rubella (MMR), chicken pox, hepatitis B, and tdap (tetanus/pertussis).

Personal Health History: Please indicate which diseases or problems you currently have or have had in the past and explain "yes" answers on the lines below.

Childhood Diseases			**Chronic or Continuing Problems**					
Measles (Regular, Hard, Red)	Yes	No	Anemia	Yes	No	Heart Disease	Yes	No
Rubella (3 day)	Yes	No	Anxiety	Yes	No	Congenital Heart Problems	Yes	No
Chicken Pox	Yes	No	Arthritis	Yes	No	Hemophilia	Yes	No
Mumps	Yes	No	Asthma	Yes	No	Hepatitis B	Yes	No
			Chronic Back Problem	Yes	No	Hepatitis C	Yes	No
Acute Diseases			Cancer	Yes	No	High Blood Pressure	Yes	No
Hepatitis A	Yes	No	Chronic Cough	Yes	No	Frequent Indigestion	Yes	No
Infectious MoNonucleosis	Yes	No	Colitis/Colon Problems	Yes	No	Kidney/Bladder Problems	Yes	No
Pleurisy	Yes	No	Convulsions or Seizures	Yes	No	Malaria	Yes	No
Pneumonia	Yes	No	Depression	Yes	No	Mental Disorders	Yes	No
Poliomyelitis	Yes	No	Diabetes	Yes	No	Sinusitis	Yes	No
Repeated bouts of Strep Throat	Yes	No	Diminished Hearing	Yes	No	Tuberculosis	Yes	No
Other (list below)	Yes	No	Dizziness/Fainting	Yes	No	Drug Allergies	Yes	No
			Excessive Drinking or Drug Use	Yes	No	Other Allergies	Yes	No
			Headaches	Yes	No	Other (explain below)	Yes	No

Please explain all "Yes" answers, any surgeries, allergies, and any serious injuries (broken bones, etc.):

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Current Medications: ____

I do hereby consent, authorize, and request health services personnel and any physician or medical representative to whom referral is made to conduct treatment which may deem advisable in the event should I require medical care while a student at Southeast Missouri Hospital College of Nursing and Health Sciences.

____　　________________________
Legal Signature　　Date