SoutheastHEALTH
College of Nursing & Health Sciences

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 fill out the form in its entirety. Use "N/A" when applicable.

_____

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

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

Measles (Regular, Hard, Red)	Yes	No
Rubella (3 day)	Yes	No
Chicken Pox	Yes	No
Mumps	Yes	No

Acute Diseases

Hepatitis A	Yes	No
Infectious MoNonucleosis	Yes	No
Pleurisy	Yes	No
Pneumonia	Yes	No
Poliomyelitis	Yes	No
Repeated bouts of Strep Throat	Yes	No
Other (list below)	Yes	No

Chronic or Continuing Problems

Anemia	Yes	No
Anxiety	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Chronic Back Problem	Yes	No
Cancer	Yes	No
Chronic Cough	Yes	No
Colitis/Colon Problems	Yes	No
Convulsions or Seizures	Yes	No
Depression	Yes	No
Diabetes	Yes	No
Diminished Hearing	Yes	No
Dizziness/Fainting	Yes	No
Excessive Drinking or Drug Use	Yes	No
Headaches	Yes	No

Heart Disease	Yes	No
Congenital Heart Problems	Yes	No
Hemophilia	Yes	No
Hepatitis B	Yes	No
Hepatitis C	Yes	No
High Blood Pressure	Yes	No
Frequent Indigestion	Yes	No
Kidney/Bladder Problems	Yes	No
Malaria	Yes	No
Mental Disorders	Yes	No
Sinusitis	Yes	No
Tuberculosis	Yes	No
Drug Allergies	Yes	No
Other Allergies	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