Health History Form

The following is information concerning medical history, including allergies, medications being taken, and physical impairments, to which a physician should be alerted:

GENERAL INFORMATION

____ ( ) Male ( ) Female
(LAST NAME) (FIRST) (MIDDLE) (BIRTH DATE)

PERMANENT MAILING ADDRESS:

____
(STREET) (CITY) (STATE) (ZIP CODE) (TELEPHONE)

HEALTH PROBLEMS – List any continuing health problems: ____________________

____

____

DRUG ALLERGIES AND REACTION – List any drug allergies and briefly describe what happened:

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MEDICINES – List any medicines, pills or injections (prescription and over-the-counter) you take regularly:

____

____

HISTORY – Check if you have ever had any of the following:

____ Anemia
____ Asthma/hay fever/allergy
____ Back problems
____ Bladder/kidney problem
____ Epilepsy/convulsions
____ High blood pressure
____ Ulcer/stomach problem
____ Heart problems (describe)
____ Jaundice/hepatitis
____ Protein/sugar in urine
____ Surgery ____________________
(TYPE AND YEAR)
____ Emotional/mental problems
____ Drug/alcohol problems

____ Have you ever lived in close contact with anyone who had tuberculosis?
TB skin test: _____ negative ____ year TB Medicines Taken: ____________________
_____positive ____ year ____________________
_____never tested

Anything else that we should be aware of? ____________________

FAMILY MEDICAL HISTORY

Has anyone in your family had any of the following problems?

____ Asthma/hay fever
____ Diabetes
____ Heart disease
____ High blood pressure
____ Sickle cell/anemias

Copies of this form will be kept by the Xavier University Campus Police and the Office of Study Abroad. The original will be kept by the director of the study abroad program that the student is participating in.