STUDENT HEALTH HISTORY FORM

General Information:

☐ Male ☐ Female

_____

(LAST NAME) (FIRST) (MIDDLE) (BIRTH DATE)

Permanent Mailing Address:

_____

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

Health Problems: I have the following health problems [*list any continuing health problems; write "**none**" if not applicable*]: _____

_____

_____

Drug Allergies and Reaction: I have the following drug allergies and reactions [*list any drug allergies and briefly describe what happened; write "**none**" if not applicable*]: _____

_____

_____

Medicines: I regularly take the following medicines [*include any pills or injections, prescription and over-the-counter medications; write "**none**" if not applicable*]: _____

_____

_____

Medical History: I have had the following [*check if **you** have ever had any of the following and explain below]*:

- ☐ Anemia
- ☐ Asthma or Allergies
- ☐ Arthritis or Back problems
- ☐ Bladder or Kidney problems
- ☐ Blood Clot(s) or bleeding problems
- ☐ Cancer or Leukemia
- ☐ Epilepsy, Seizure Disorder or Syncope (Fainting)
- ☐ High Blood Pressure
- ☐ Ulcer or Inflammatory Bowel Disease
- ☐ Heart Problems
- ☐ Migraine headache
- ☐ Eating Disorder
- ☐ Psychosis or Schizophrenia
- ☐ Anxiety or Depression
- ☐ Substance Abuse
- ☐ Surgery
- ☐ None of the above

If you checked any of the above, please provide a brief explanation: _____

_____

_____

Have you ever lived in close contact with anyone who had tuberculosis? ☐ Yes ☐ No

TB skin test: _____ negative _____ year
_____ positive _____ year
_____ never tested

TB Medicines Taken:
_____

Family Medical History [*check if anyone in **your family** has have ever had any of the following health problems]:*

- ☐ Blood Clots or Bleeding Problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Sickle Cell Disease

Please use the space provided to inform us if there is anything else that is not covered by this form that we should be aware of: _____
_____
_____

*** * * * * * * ***

By signing below, I certify that I have accurately provided my health history information above.

_____ _____
Participant's Signature Date

Banner ID: _____