FACULTY/EMPLOYEE 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: _____
_____
_____

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

In the event I require emergency medical care in connection with my participation in an overnight travel experience, I authorize Xavier to release the information provided on this form to medical personnel to facilitate that medical care. Xavier will not use the information disclosed on this form for any other purpose, including any assessment of my ability or fitness to participate in an overnight travel experience.

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

_____ _____
Participant's Signature Date

_____
Banner ID