



# HEALTH RECORD

Please complete this form and return it to the school via airmail, express mail, or facsimile

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Sex  M  F Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Color of Eyes: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Distinguishing Marks/Scars: \_\_\_\_\_

## Medical History

(Complete before seeing your physician)

### Family History:

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Check if any of your relatives have ever been diagnosed with any of the following:

- |  |              |  |              |  |              |
|--|--------------|--|--------------|--|--------------|
| <input type="checkbox"/> High Blood Pressure | Relationship | <input type="checkbox"/> Diabetes                      | Relationship | <input type="checkbox"/> Kidney Stones/Disease | Relationship |
| <input type="checkbox"/> Cancer              |              | <input type="checkbox"/> Stomach or Intestinal Disease |              | <input type="checkbox"/> Epilepsy/Convulsions  |              |
| <input type="checkbox"/> Allergies (which?)  |              | <input type="checkbox"/> Mother DES                    |              | <input type="checkbox"/> Tuberculosis          |              |

### Personal History:

Check if you have been diagnosed with any of the following. Comment on all checked conditions in the space below.

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Scarlet Fever             | <input type="checkbox"/> Insomnia                         | <input type="checkbox"/> Pain/Pressure in Chest            | <input type="checkbox"/> Recurrent Diarrhea            |
| <input type="checkbox"/> Measles                   | <input type="checkbox"/> Emotional Disorders              | <input type="checkbox"/> Chronic Cough                     | <input type="checkbox"/> Rupture, Hernia               |
| <input type="checkbox"/> German Measles            | <input type="checkbox"/> Eating Disorders                 | <input type="checkbox"/> Palpitations (Heart)              | <input type="checkbox"/> Recent Gain or Loss of Weight |
| <input type="checkbox"/> Mumps                     | <input type="checkbox"/> Recurrent Headache               | <input type="checkbox"/> High or Low Blood Pressure        | <input type="checkbox"/> Dizziness, Fainting           |
| <input type="checkbox"/> Chickenpox                | <input type="checkbox"/> Head Injury with Unconsciousness | <input type="checkbox"/> Rheumatic Fever or Heart Murmur   | <input type="checkbox"/> Weakness, Paralysis           |
| <input type="checkbox"/> Malaria                   | <input type="checkbox"/> Tuberculosis                     | <input type="checkbox"/> Mitral Valve Prolapse             | <input type="checkbox"/> Sexually Transmitted Disease  |
| <input type="checkbox"/> Gum or Tooth Trouble      | <input type="checkbox"/> Shortness of Breath              | <input type="checkbox"/> Disease or Joints Injury          | <input type="checkbox"/> Herpes                        |
| <input type="checkbox"/> Sinusitis                 | <input type="checkbox"/> Allergy                          | <input type="checkbox"/> "Trick" Knee, Shoulder...         | <input type="checkbox"/> Albumin/Sugar in Urine        |
| <input type="checkbox"/> Eye Trouble               | ..... Penicillin  | <input type="checkbox"/> Back Problems                     | <input type="checkbox"/> Urinary Tract Infection       |
| <input type="checkbox"/> Ear, Nose, Throat Trouble | ..... Sulfonamides  | <input type="checkbox"/> Tumor, Cancer, Cyst               | <input type="checkbox"/> Convulsions or Epilepsy       |
| <input type="checkbox"/> Surgery                   | ..... Other medications                                   | <input type="checkbox"/> Stomach or Intestinal Trouble     | <input type="checkbox"/> Loss of Consciousness         |
| ..... Appendectomy                                 | ..... Foods (which?)                                      | <input type="checkbox"/> Gallbladder Trouble or Gallstones |  |
| ..... Tonsillectomy                                | ..... Other   |  |  |
| ..... Hernia Repair                                | <input type="checkbox"/> Hepatitis A/B                    |  |  |
| ..... Other  |   |  |  |
| <input type="checkbox"/> Diabetes                  |   |  |  |

### FEMALES ONLY

- Have you had any gynecological problems?

Remarks:

**Other Relevant Conditions:**

Has your physical activity been restricted during the past five years? (Give reasons and durations)

Have you consulted or been treated by clinics, physicians, or other practitioners within the past five years? (Other than routine checkups?)

Have you ever had a positive skin test for T.B.? If yes, when and what was done about it?

Have you had any illness or injury or been hospitalized other than already noted? (Give details)

Have you consulted or been treated by a psychiatrist or clinical psychologist?

Are you taking medication?

List any hospitalization with diagnosis and date in the space below.

**Hospitalizations/Remarks/Additional Information:**

**Check all of the following systems in which there are abnormalities:**

Head, ears, nose, or throat

Respiratory

Genitourinary

Lose or seriously impaired function of any paired organ

Abnormal medical condition or any surgery. If checked, describe in full above or on a separate sheet.

Neurological

Muskuloskeletal

Hernia

Gastrointesinal

Metabolic/Endocrine

Skin

Eyes

**Immunization Record**

Date	Vaccinations	Date	Other Vaccinations
	German Measles (Rubella)		
	Hepatitis A		
	Hepatitis B		
	Smallpox		
	Polio		
	Measles Vaccine		
	Cholera (most recent)		
	Tetanus		
	Mumps		
	D.P.T.		

If you wear glasses or contact lenses, please state your prescription:

Right eye	
Left eye	