Saint Mary-of-the-Woods College

General Health History 2014-2015

Confidential

Please complete this section before going to your physician for examination.

Last Name	First Name	Middle Name		Date of Birth
Home Street Address	City or Town	State	Postal Code	Country
Name, Relationship, and Address of Next of Kin				Home Telephone Number
Next of Kin's Business Address				Business Telephone Number

Family History

Relationship	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brother/Sister					
Brother/Sister					
Brother/Sister					
Brother/Sister					

Have you or your relatives had any of the following?

1. Tuberculosis Y N
2. Diabetes Y N
3. Kidney/Heart Disease Y N
4. Asthma, Hay Fever Y N
5. Epilepsy, Seizures Y N
6. Cancer Y N
7. Hernia Y N
8. Mononucleosis Y N
9. Pneumonia Y N
10. Polio Y N
11. Rheumatic Fever Y N

If you have answered yes on any of the above, comment below with item number and the relationship of family member:

_____

_____

_____

_____

General Health History, Page Two

Name: _____

Personal History

Have you ever had any of the following? Please comment on all positive (yes) answers in the space provided.

Scarlet Fever	Y	N	Injured Knee, Shoulder	Y	N
Measles	Y	N	Disease of Joints	Y	N
German Measles	Y	N	Tumor, Cancer, Cyst	Y	N
Mumps	Y	N	Recent Weight Gain/Loss	Y	N
Chicken Pox	Y	N	Dizziness, Fainting	Y	N
Sinusitis	Y	N	Albumin/Sugar in Urine	Y	N
Eye Trouble	Y	N	Frequent Urination	Y	N
Ear, Nose, Throat Trouble	Y	N	Head injury w/unconsciousness	Y	N
Frequent Depression	Y	N	Rheumatic Fever/Heart Murmur	Y	N
Frequent Anxiety	Y	N	Irregular Menstrual Periods	Y	N
Worry/Nervousness	Y	N	Severe Cramps	Y	N
Recurrent Headache	Y	N	Excessive Menstrual Flow	Y	N

Have you had allergic reactions to the following medicines or allergic reactions to food?

Penicillin	Y	N
Sulfonamides	Y	N

Foods (Which) _____

Other Allergic Reactions: _____

Have you had any of these surgeries? If so, please indicate date of surgery.

Appendectomy	Y	N	If yes, Date:_____
Tonsillectomy	Y	N	If yes, Date:_____
Hernia Repair	Y	N	If yes, Date:_____
Other:_____	Y	N	If yes, Date:_____

Has your physical activity been restricted during the past five years?	Y	N
Have you had difficulty with school, studies, or teachers?	Y	N
Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem?	Y	N
Have you had any illness or injury or been hospitalized within the past five years?	Y	N

Please place any comments to positive answers in the following section.

_____

_____

Parental Consent: The following consent form should be signed by parents so that emergency procedures may be promptly carried out, and so that no unnecessary delays will occur with less urgent procedures. However, no operation will be performed, except in extreme emergency, without parents being contacted and fully informed.

Signature of Parents/Guardian _____ Date_____