

Yes	No	
___	___	Shoulder, elbow, wrist problem
___	___	Other bone or joint problem
		Explain: _____
		CHRONIC DISEASE
___	___	Cancer
___	___	Diabetes
___	___	Inflammatory bowel disease
___	___	Thyroid problems
___	___	Other chronic disease
		Explain: _____
		INFECTIOUS DISEASE
___	___	Chickenpox
___	___	Hepatitis A B C (circle one)
___	___	Hepatitis chronic
___	___	Measles
___	___	Meningitis
___	___	Mononucleosis
___	___	Mumps
___	___	Rheumatic fever
___	___	Rubella
___	___	Sexually transmitted disease (STD)
		Explain: _____
___	___	Tuberculosis
___	___	Whooping cough
___	___	Other infectious disease
		Explain: _____
		MENTAL HEALTH
___	___	Anxiety
___	___	Bipolar disorder
___	___	Depression
___	___	Difficulty with concentration
___	___	Eating disorder
___	___	Excessive mood changes
___	___	Memory problems
___	___	Sleep difficulty
___	___	Other: _____

Yes	No	
___	___	OTHER HEALTH PROBLEMS
___	___	Skin problems
___	___	Unexplained weight gain or loss
___	___	Other health problems
		Explain: _____
		WOMEN'S HEALTH
___	___	Age of onset of menstruation ___
___	___	Menstrual problems
		Explain: _____
___	___	Use birth control
		Specify: _____
		No. of pregnancies _____
		No. of live children _____
___	___	Other women's health problems
		Explain: _____

		LIFESTYLE
___	___	Alcohol use
		___ per day ___ wk ___ mo ___
		Type: _____
___	___	Smoking/Tobacco use
		Type: _____
		Frequency: _____
		Age when started: _____
___	___	Other drug use
		___ per day ___ wk ___ mo ___
		What kind: _____
___	___	Physical Activity
		What kind: _____
		How much: _____
		___ per day ___ wk ___
		mo ___ How
		long _____
___	___	Physical restrictions or limitations
		Explain: _____
___	___	Cultural or religious issues
		Explain: _____

Family History

Yes	No		Relationship
___	___	Alcoholism	_____
___	___	Arthritis	_____
___	___	Asthma, hayfever, hives	_____
___	___	Bleeding disorder	_____
___	___	Cancer	_____
___	___	Death before age 50	_____
___	___	Diabetes	_____
___	___	Epilepsy / Seizures	_____
___	___	Heart Disease	_____
___	___	High blood pressure	_____

Yes	No		Relationship
___	___	High cholesterol	_____
___	___	Kidney trouble	_____
___	___	Psychological problems	_____
___	___	Stomach or bowel trouble	_____
___	___	Thyroid problems	_____
___	___	Tuberculosis	_____
___	___	Other	_____

Additional Information: _____

The above information is true and complete to the best of my knowledge and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and is protected by law.

Signature of Student

Date