HEALTH HISTORY INFORMATION

_____

Last name First Middle Age Birth date

In order for us to be aware of any health problems that you may have, it would be helpful if you would fill out the information asked for below.
Place and **X** beside any of the following conditions that apply to you (student).

_____Allergy (medications)
_____Anemia
_____Arthritis
_____Asthma
_____Back pain
_____Concussion
_____Diabetes
_____Emotional problems
_____Fractures
_____Hearing Problems
_____Heart murmur
_____Hernia
_____Other Health Problems (please explain)

_____Kidney Problems
_____Menstrual cramps
_____Migraine Headaches
_____Seizures
_____Sinus Problems
_____Skin Rashes
_____Sore Throats
_____Tuberculosis
_____Valley Fever
_____Operations
_____Last Tetanus booster (date)

_____
_____

Please give details about any category that you have marked with an **X**.
_____
_____
_____

Apart from vitamins, are you taking any medications? _____

What medication? _____ What for? _____

Are you allergic to anything such as foods, plants, insects? _____

What? _____

Reaction? _____

Do you need a special diet or have any food problems? _____

Give Details _____

Do you have any special health needs or problems that we should know about?

_____