STUDENT HEALTH HISTORY

Mercy College

Confidential for Health Service Staff

Name Last First Middle

Permanent Address City State Zip

Emergency Contact Name Telephone

Gender: M ___ F

Have you had or do you have any of the following:

		No	Yes
1.	Eye disorders	___	___
2.	Ears/Nose/Throat disorder	___	___
3.	Migraine headaches	___	___
4.	Seizures/Epilepsy	___	___
5.	Thyroid disease	___	___
6.	Heart disease/murmur/ rheumatic fever	___	___
7.	High blood pressure	___	___
8.	Asthma/chronic respiratory disorders	___	___
9.	Hay fever/Sinus disorder	___	___
10.	Stomach/intestinal disorder	___	___
11.	Anorexia/bulimia/other eating disorder	___	___
12.	Kidney/bladder disorder	___	___
13.	Liver/gallbladder/spleen	___	___
14.	Diabetes	___	___
15.	Joint/muscle disorder	___	___
16.	Skin disorder	___	___
17.	Reproductive organs disorders	___	___
18.	Blood disorder/Mono	___	___
19.	Cancer/other malignancies	___	___
20.	Childhood/communicable diseases/Chicken Pox	___	___
21..	Other _____	___	___

Have you ever had surgery?
No ___ Yes ___ Why? _____

Have you ever been hospitalized?
No ___ Yes ___ Why?_____

Are you taking any medications, vitamins, etc.?
No ___ Yes ___ (include birth control pills & over the counter drugs)

Name of drug(s)_____

SID#

Date of Birth

Weight Height

Do you have a physical, learning or emotional disability that you want the Health Service to be aware of?

No ___ Yes ___ Explain:

Please list all the dates of the following immunizations:

1. DPT or DT and tetanus booster (Td)

2. Oral polio vaccine (OPV) or polio injection

3. Measles, mumps, rubella (MMR) and boosters

4. Hepatitis B

5. Date of last tuberculosis skin test or x-ray and result

_____

6. BCG _____

7. Others _____

Family Health History (any person related by blood)

No	Yes		Member
___	___	Cancer	_____
___	__	Diabetes/ Thyroid	_____
___	___	Heart Disease	_____
___	___	Respiratory Disorders	_____
___	___	Stomach Disorders	_____
___	___	Stroke	_____
___	___	Tuberculosis (Active)	_____
___	___	Alcohol/Drug abuse	_____
___	___	Sudden, Unexpected Death, before age 60	_____
___	___	Other _____.	

Any known allergies or adverse reaction to any drugs, antibiotic, food, etc.?

No ___ Yes ___ List allergies:

_____

Student Signature, Date