

Jamestown College Health History Report

Name	Last	First	Middle	F M Sex	Age
Home Address		City	State	Zip	Home Phone
Date of Birth	Place of Birth(City State Country)			S M Marital Status	Maiden Name
Name and Relationship of Person to be reached in case of emergency				Home Phone	
Address(if different than above)				Work Phone	
Semester and year you plan to enroll		Major field of study		Dates previously enrolled at JC	

Family History

	Age	State of Health	Occupation	Age of Death	Cause of Death	Have any of your relatives had any of the following?	
						Yes	Relationship
Father						<input type="checkbox"/>	Hypertension
Mother						<input type="checkbox"/>	Tuberculosis
Brothers						<input type="checkbox"/>	Daibetes
						<input type="checkbox"/>	Kidney Disease
Sisters						<input type="checkbox"/>	Heart Disease
						<input type="checkbox"/>	Arthritis
						<input type="checkbox"/>	Stomach Disease
						<input type="checkbox"/>	Asthma
						<input type="checkbox"/>	Epilepsy, convusions
						<input type="checkbox"/>	Cancer

Number of Children(if you are a parent): _____

Personal History

check box if answer is yes

Explain Yes Answers on back

Yes		Yes		Yes	
<input type="checkbox"/>	Head Injury with Unconsciousness	<input type="checkbox"/>	Palpitations (Heart)	<input type="checkbox"/>	Albumin/Sugar in Urine
<input type="checkbox"/>	Recurrent Head Ache	<input type="checkbox"/>	Pain/Pressure in Chest	<input type="checkbox"/>	Urinary Infection
<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	High or Low Blood Pressure	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	Rhumatic Fever	<input type="checkbox"/>	Knee, Shoulder, etc. Problem
<input type="checkbox"/>	Convulsion	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Back Problems
<input type="checkbox"/>	Eye trouble	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Weakness, Paralysis
<input type="checkbox"/>	Ear, Nose, Throat trouble	<input type="checkbox"/>	Stomach or Intestinal Trouble	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	Gum or Tooth Trouble	<input type="checkbox"/>	Gallbladder Trouble or Gallstones	<input type="checkbox"/>	Frequent Anxiety
<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	Recurrent Diarrhea	<input type="checkbox"/>	Frequent Depression
<input type="checkbox"/>	Recurrent Colds	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Surgery:
<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	Tumor, Cancer or Cyst	<input type="checkbox"/>	Appendectomy
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Rupture, Hernia	<input type="checkbox"/>	Tonsilectomy
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Recent Gain or Loss of Weight	<input type="checkbox"/>	Hernia Repair
<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Other
<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	

Yes	Use back of sheet to explain "yes" answers	Yes	
<input type="checkbox"/>	A. Has your physical activity been restricted during the past five years?	<input type="checkbox"/>	F. Do you have problems other than those already listed which might require attention from our staff?
<input type="checkbox"/>	B. Have you received treatment or counseling for a nervous condition, drug related or emotional problem?	<input type="checkbox"/>	G. Are you allergic to any medications? If yes, list
<input type="checkbox"/>	C. Have you consulted or been treated by clinic, physicians or other practitioners for illness or injury or been hospitalized within the past 5 years?	<input type="checkbox"/>	
<input type="checkbox"/>	D. Do you have a history of any severe or chronic condition?	<input type="checkbox"/>	
<input type="checkbox"/>	E. Do you have any type of handicap or condition which limits functioning?	<input type="checkbox"/>	

* Please attach copy of Certificate of Immunization

This is to certify that the above information is correct to the best of my knowledge

Student Signature

Date