

# MEDICAL HISTORY

ENTIRE FORM NEEDS TO BE COMPLETED BY THE STUDENT

Student's Name \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone \_\_\_\_\_

Name of Emergency Contact \_\_\_\_\_ Telephone Number \_\_\_\_\_

Do you have medical insurance? *Please circle YES or NO*

**If YES**, Name of Insurance Company \_\_\_\_\_ and ID Number \_\_\_\_\_

**If NO**, name of person responsible \_\_\_\_\_

Medical Clinic \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Doctor's Name \_\_\_\_\_

Year of last Physical \_\_\_\_\_ Present Physical Condition \_\_\_\_\_

Any Allergies? **YES** or **NO**, *if yes please list* \_\_\_\_\_

Any Major Past Illnesses? **YES** or **NO**, *if yes please list* \_\_\_\_\_

Any Past Surgeries? **YES** or **NO**, *if yes please list* \_\_\_\_\_

Any Drugs you cannot take? **YES** or **NO**, *if yes please list* \_\_\_\_\_

Are you presently taking any medications? **YES** or **NO**

**If YES**, names of medications \_\_\_\_\_

Any other important medical information \_\_\_\_\_

***PLEASE MAKE SURE THAT YOU ANSWERED EVERY QUESTION COMPLETELY, THANK YOU.***

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date