

CLARKSON UNIVERSITY
Health History Report

Please Print

Name _____ female male SS# _____

Date of Birth _____ Home Address _____

Telephone _____ Student # _____ Undergrad Student
Grad Student

<u>Do you , or have you:</u>	YES	NO
1) require use of a wheelchair?	0	0
2) require special housing due to health conditions ?	0	0
3) been refused employment for health reasons ?	0	0
4) been restricted in your work for health reasons ?	0	0
5) require a special diet?	0	0
6) been refused for or discharged from military service for health reasons?	0	0
7) had loss of function of any body organ?	0	0
8) object to medical treatment?	0	0
9) object to blood transfusions in a life threatening situation?	0	0
10) receive allergy injections?	0	0

Please explain in detail the circumstances for any yes answer to the above questions.

11) Do you have any allergies to medications, food, serums, hay fever, other? _____
If yes, please list: _____

12) Have you ever been hospitalized? _____ If so, what for and when? _____

13) Have you had any surgery? _____ If so, what for and when? _____

14) Do you regularly use prescription medications? _____ Please list – prescribed by
your medical provider. _____

15) Do you take any over the counter medications or supplements (aspirin, laxative, or
vitamins) _____

16) Do you have medical disabilities? _____ If so, please list them _____

17) Do you have a learning disability? _____

18) Have you had any serious illness or injuries? _____ if so, please list them with dates, i.e. fractures, hepatitis, _____

Mark any problems you have or have had that have been diagnosed or treated by a physician or other health care professional.

- | | | | | | |
|-----------------------------------|-----|----|---------------------------|-----|----|
| 19) Alcoholism or alcohol abuse | Yes | No | 41) Hypoglycemia | Yes | No |
| 20) Anemia or other blood disease | Yes | No | 42) Kidney problems | Yes | No |
| 21) Anorexia | Yes | No | 43) Knee problems | Yes | No |
| 22) Asthma | Yes | No | 44) Mental Health issues* | Yes | No |
| 23) Back problems of any type | Yes | No | 45) Migraine headaches | Yes | No |
| 24) Bladder infection-more than 1 | Yes | No | 46) Mono | Yes | No |
| 25) Bleeding disorders | Yes | No | 47) Nervous stomach | Yes | No |
| 26) Bronchitis-chronic | Yes | No | 48) Nervous disorder | Yes | No |
| 27) Bulimia | Yes | No | 49) Obesity | Yes | No |
| 28) Cancer | Yes | No | 50) Phlebitis | Yes | No |
| 29) Chicken pox | Yes | No | 51) Pneumonia | Yes | No |
| 30) Colitis | Yes | No | 52) Rheumatic fever | Yes | No |
| 31) Depression | Yes | No | 53) STDs | Yes | No |
| 32) Diabetes | Yes | No | 54) Sinus trouble-chronic | Yes | No |
| 33) Drug abuse or addiction | Yes | No | 55) Skin diseases/rashes | Yes | No |
| 34) Epilepsy or convulsions | Yes | No | 56) Stomach or intestinal | Yes | No |
| 35) Ear diseases or problems | Yes | No | 57) Suicide attempt | Yes | No |
| 36) Eye diseases or problems | Yes | No | 58) Thyroid problems | Yes | No |
| 37) Hearing loss | Yes | No | 59) Tension headaches | Yes | No |
| 38) Heart problem | Yes | No | 60) Tuberculosis | Yes | No |
| 39) Hepatitis/liver problems | Yes | No | | | |
| 40) High blood pressure | Yes | No | | | |

***Please include ADD/ADHD, Generalized Anxiety Disorder.**

Men only (question #61 only)

61) Any problems with prostate gland, testicles or penis Yes No

Women only (questions 62-68)

- | | | | | | |
|---------------------------------------------------------|-----|----|-----------------------------------------|-----|----|
| 62) Menstrual problems-irregular periods, severe cramps | | | | Yes | No |
| 63) Pelvic infections | Yes | No | 66) Abnormal pap test | Yes | No |
| 64) Ovarian cysts | Yes | No | 67) Fibrocystic or other breast disease | Yes | No |
| 65) Abnormal pap test | Yes | No | 68) Frequent vaginal infections | Yes | No |

Have you ever.....

- 1) Smoked tobacco? Yes No
- a) Do you now? Yes No
- b) How many years have you smoked? _____
- c) How many packs do/did you smoke per day? _____
- 2) Use alcohol? Yes No
- a) Do you now? Yes No
- b) How much do/did you drink per week? _____
- 3) Used street drugs: Yes No
- a) Do you now? Yes No
- b) Drugs used _____
- 4) Been exposed to occupational hazards, i.e. chemical radiation? Yes No

Family History.... Has anyone in your family, living or dead, had: (family means blood relatives, i.e. parents, grandparents, siblings, children).

- | | | | |
|------------------------|--------|-----------------------|--------|
| 1) Diabetes | Yes No | 8) Sickle cell anemia | Yes No |
| 2) Cancer | Yes No | 9) Bleeding trait | Yes No |
| 3) High blood pressure | Yes No | 10) Stroke | Yes No |
| 4) Mental illness | Yes No | 11) Suicide | Yes No |
| 5) Alcoholism | Yes No | 12) Stomach disease | Yes No |
| 6) Tuberculosis | Yes No | 13) Asthma | Yes No |
| 7) Heart trouble | Yes No | 14) Epilepsy | Yes No |

Please give details of any pertinent information which has not been covered by this form, or give positive responses on the information above. _____

I, the undersigned, do hereby certify that the answers to the above questions are true to the best of my knowledge.

Student's Signature

Date

History reviewed by: _____