

**STUDENT MEDICAL HISTORY**  
 (To be completed by applicant)

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex (circle one) Male Female

Address: \_\_\_\_\_  
 \_\_\_\_\_

Last time you were examined by a Doctor: \_\_\_\_\_

Reason: \_\_\_\_\_

.....  
 Date of last physical examination: \_\_\_\_\_

Please list all symptoms:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Routine check-up – no symptoms \_\_\_\_\_

**Personal History:**

Illness – Have you ever had: (circle answer)

Rheumatic fever or heart disease	No	Yes	Bladder or kidney disease	No	Yes
Any bone or joint disease	No	Yes	Epilepsy	No	Yes
Neuritis or Neuralgia	No	Yes	Tuberculosis	No	Yes
Bursitis, Sciatica or Lumbago	No	Yes	Diabetes	No	Yes
Polio or Meningitis	No	Yes	Cancer	No	Yes
Venereal Disease	No	Yes	High or Low Blood Pressure	No	Yes
Arthritis or Rheumatism	No	Yes	Hives or Eczema	No	Yes
Colitis or other bowel disease	No	Yes	Frequent infections or boils	No	Yes
Hemorrhoids or any rectal disease	No	Yes	Nervous breakdown	No	Yes
Anemia	No	Yes	Any other diseases	No	Yes
Jaundice or liver disease	No	Yes	If yes, describe: _____		
Chicken Pox	No	Yes	_____		
Mumps	No	Yes	_____		

(over)

**Surgery:** (circle answer)

Have you had any operations? No Yes  
If Yes:

Type \_\_\_\_\_ Year \_\_\_\_\_  
Type \_\_\_\_\_ Year \_\_\_\_\_  
Type \_\_\_\_\_ Year \_\_\_\_\_  
Type \_\_\_\_\_ Year \_\_\_\_\_

Have you ever been advised to have any surgical  
Operation which has not been done? No Yes

Give details: \_\_\_\_\_  
\_\_\_\_\_

Have you been hospitalized for any illness? No Yes  
Give details: \_\_\_\_\_  
\_\_\_\_\_

**Injury:** (circle answer)

- 1. Have you sustained any injury which has required Worker’s Compensation? No Yes  
If so, please describe: \_\_\_\_\_
- 2. Do you have any physical limitations as a result of this injury? No Yes  
If so, please describe: \_\_\_\_\_  
\_\_\_\_\_

**Do you have now or have you had:** (circle answer)

Frequent or severe headaches	No	Yes	Recurrent nose bleeds	No	Yes
Fainting or unconscious spells	No	Yes	Shortness of breath	No	Yes
Blurred or double vision	No	Yes	Purple lips or fingers	No	Yes
Spots before eyes	No	Yes	Earaches or hearing problems	No	Yes
Any change in vision	No	Yes	Backaches	No	Yes
Infection or pain around eyes	No	Yes	Strange taste or loss in taste	No	Yes
Palpitations or fluttering of the heart	No	Yes	Strange persistent odors	No	Yes

**I certify that the above information is true and correct to the best of my knowledge.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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