WASHINGTON•SARATOGA BOCES
BOARD OF COOPERATIVE EDUCATIONAL SERVICES
WARREN•HAMILTON•ESSEX

Southern Adirondack Education Center
1051 Dix Avenue
Hudson Falls, NY 12839
http://wswheboces.org
voice: 518/746-3508
fax: 518/746-3409

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: _____
_____

Prescription/Non-prescription drugs: (circle answer)

Do you use any prescription or non-prescription medications? No Yes

If so, list: _____
_____
_____
_____

Illness: (circle answer)

Are you under treatment for any illness? 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