MARYMOUNT COLLEGE
PALOS VERDES, CALIFORNIA

HEALTH HISTORY FORM

WHAT is the purpose of this form? The Health History form provides the Student Health Center with a brief profile of the student's family and personal medical background.

WHO should complete this form? This form should be completed by the student. All information on the Health History form is kept confidential.

WHEN is this form due? Please forward the Health History form to the Student Health Center by **Fall, 2007**. Fax transmittals are acceptable. The Student Health Center's direct fax line is on the bottom of this form.

PLEASE TYPE OR PRINT THE FOLLOWING IN BLACK INK AND IN THE ENGLISH LANGUAGE.

Name: _____ Date of Birth: ____/____/_____
LAST FIRST MIDDLE INITIAL

Address: _____

City/ State/ Zip/ Country: _____

Telephone: Home _____ Cell _____ Email: _____ ❑ Male ❑ Female

FAMILY HISTORY

Has any parent, grandparent or sibling had any of the following?

	Yes	No		Yes	No	Age
High blood pressure	____	____	Migraines	____	____	Father _____
Anemia	____	____	Problem drinker	____	____	Mother _____
Bleed disorder	____	____	Drug User	____	____	Brother(s) _____
Epilepsy	____	____	Unexplained death	____	____	_____
Ulcers	____	____	Mental illness	____	____	Sister(s) _____
Allergy, asthma	____	____	Other	____	____	_____
Stroke or heart attack before age 55	____	____	Specify: _____ _____			

PERSONAL HISTORY

1. Have you ever had surgery? ❑ Yes ❑ No If yes, explain: _____
2. Have you ever been hospitalized? ❑ Yes ❑ No If yes, explain: _____
3. Have you ever had any significant injuries or medical illnesses/ conditions? ❑ Yes ❑ No If yes, explain: _____
4. List any medications you are currently taking (include nonprescription drugs): _____
5. Are you allergic to any medications? ❑ Yes ❑ No If yes, list: _____
6. Have you had an allergic reaction to any food, insect stings or other substances? ❑ Yes ❑ No If yes, explain: _____

PSYCHOLOGICAL HISTORY

If you are currently seeing a psychologist, psychiatrist or therapist and would like to provide the information, please complete the area below:

Therapist's Name:_____ Telephone: _____
Address: _____
City/ State/ Zip/ Country: _____

I hereby certify that, to the best of my knowledge, the information on this form is complete and accurate.

Student's Signature: _____ Date: _____