REPORT OF MEDICAL HISTORY

To the Student: Information you provide will have no effect upon your admission to University. It will be used solely as an aid in providing necessary health care while you are a student.

This information is strictly for the use of the Health Services and will not be released to anyone without your knowledge and consent.

SEX M☐ F☐

Last Name (Print) First Name Middle

Home Address (Number and Street) City or Town State Zip Code Date of Birth

Name, Relationship, and Address of Next of Kin Home Telephone Number

Next of Kin's Business Address Business Telephone Number

Martial Status Citizenship

S M

Class you are entering

Do you have medical insurance? Yes___ No____

Name of Company (A student insurance plan is available in Office of Student Affairs)

Immunization Completed	Yes	No	Date last injection	Have you had any of the following?			Relationship
Tetanus				Tuberculosis			
Diphtheria				Diabetes			
Small Pox				Kidney Disease			
Mumps				Heart Disease			
Rubella				Arthritis			
Polio				Stomach Disease			
Typhoid				Asthma, Hay Fever			
Other				Epilepsy, Convulsions			

PERSONAL HISTORY PLEASE ANSWER ALL QUESTIONS Comment on all positive answers in space below or on additional sheet

Have you had?	Yes	No		Yes	No		Yes	No		Yes	No
Scarlet Fever			Insomnia			Chest Pain/Pressure			Gallbladder Trouble		
Measles			Nervous Disorder			Diabetes			Gallstones		
German Measles			Frequent Depression			Chronic Cough			Recurrent Diarrhea		
Mumps			Seizures			Palpations (Heart)			Rupture Hernia		
Chicken Pox			Recurrent Colds			High Blood Press			Recent Gain/Loss		
Malaria			Recurrent Headaches			Lung Disease			Of Weight		
Gum or tooth Trouble			Head Injury with Unconsciousness			Rheumatic Fever Heart Murmur			Dizziness, Fainting Weakness, Paralysis		
Sinusitis			Hay Fever, Asthma			Disease or injury Of Joints			Venereal Disease Kidney Disease		
Eye Trouble			Tuberculosis			Other Injuries			Albumin/Sugar in Urine Frequent Urination		
Ears, Nose, Throat Trouble			Shortness of Breathe			Back Problems					
			Allergies			Tumor, Cancer, Cyst					
Surgery			Penicillin			Jaundice					
Appendectomy			Sulfonamides			Stomach or Intestinal Trouble					
Tonsillectomy			Serum								
Hernia Repair			Foods (which)								
Other			Other								

	Yes	No
A. Has your physical activity been restricted during the past five years? (Give reason s and durations)		
B. Have you had difficulty with school, studies, or teachers? (Give details)		
C. Have you received treatment or counseling for a nervous or emotional condition or personality or character disorder?		
D. Have you had any illness or injury or been hospitalized other than already noted? (Give details)		
E. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (Other than routine check-ups?)		
F. Have you been rejected for or discharged from military service because of physical, emotional, or other reasons? (If so, give reasons)		
G. Do you have any questions in regard to your health, family history, or other matter, which you would like to discuss now with a member of the staff of the Health Services?		

REMARKS OR ADDITIONAL INFORMATION

Comments on any items checked "Yes" above
(Use additional sheet if necessary)

_____
Student's Signature Date

REPORT OF HEALTH EVALUATION

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete the form below. Please comment on all positive answers. The information supplied will not be affecting the student's admission status. It will be used only as a background for providing necessary health care. This information is strictly for the use of the Health Services and will not be released without students consent. If there is a serious or chronic medical problem or you have more detailed records or recommendations, please send to the Director, Student Health Service P. O. Box 1380 Arkansas State University, State University, Arkansas 72467

SEX M F

Last Name First Name Middle

Blood Pressure_____ Height_____inches Weight_____Lbs.
Vision Right 20/ Left 20/ Overweight _____ Underweight_____
Corrected Vision Right 20/ Left 20/ Tuberculin Skin Test Positive_____/ Negative_____-
Date of Tuberculin Skin Test _____

URINALYSIS
Sugar_____
Albumin_____
Micro_____
HEMOGLOBIN (if needed) GM%
HEMATOCRIT (if needed) %
OTHER LABORATORY TESTS

Are there abnormalities of the following systems? Describe fully. Use additional sheet if needed

	Yes	No
1. Head, Ears, Nose, or Throat		
2. Respiratory		
3. Cardiovascular		
4. Gastrointestinal		
5. Hernia		
6. Eyes		
7. Genitourinary		
8. Musculoskeletal		
9. Metabolic/ Endocrine		
10. Neuropsychiatric		
11. Skin		

Is there loss or seriously impaired function of any paired organ?

Yes____ No_____

Are there any known allergies?

Have you any general comments?

Recommendations for physical activity (PE, Intramurals, ROTC) Unlimited_____Limited____Explain"

Do you have any recommendations regarding the care of the student? Yes__No__

Is the patient now under treatment for any medical or emotional condition? Yes__No___

PHYSICIAN SIGNATURE_____

ADDRESS (Print)_____

PRINT NAME _____DATE_____