



PART 1 MEDICAL HISTORY (To be completed by student)

Name of Student (Full Caps): 	Date of Birth: -----/-----/----- MM DD YY
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(1) When was the last time you did a medical? _____

(2) Have you ever been admitted to a hospital before? Yes [] No []
 Explain: _____

(3) Are you currently on medication? Yes [] No []
 Explain: _____

(4) How many alcoholic drinks you have weekly _____, daily _____, other _____?

(5) Do you have asthma, diabetes or blood pressure problems? Yes [] No []
 Explain: _____

(6) Do you have allergies? Yes [] No []
 Explain: _____

(7) Do you have frequent bouts of headache? Yes [] No []
 Explain: _____

(8) Have you ever done X- Ray, ECG or any other tests? Yes [] No []
 Explain: _____

(9) Have you ever done surgery? Yes [] No []
 Explain: _____

(10) Are you allergic to aspirin _____ or penicillin _____?

(11) Do you have any other medical condition not mentioned above? Yes [] No []
 Explain: _____

