Student Medical File

Print Name:

Last_____First_____Middle_____

Social Security Number:_____ Date of Birth_____

Date entered program_____Age_____

Emergency Contact: Name_____Relation_____

Phone_____Work_____Home_____

Past Health History

Have you ever had the following?

	Yes/No	Explain

Foot Problems:

Knee Problems:

Back Problems:

Hernia:

Dental Problems:

Allergies to Bee Sting:

Seizures:

Reading Problems:

Wear Glasses:

Hearing Problems:

Diabetes:

Tuberculosis:

Hepatitis:

Sexually Transmitted Diseases:

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Stroke:

Arthritis:

High Blood Pressure:

Frequent or severe headaches:

Deformities:

Sores that do not heal:

Do any of these cause work restrictions?

List Medications you normally take:

Name of Medication:_____

Prescribed by Dr._____**When:**_____

For what illness:_____

Date you last saw a Doctor:_____

Do Not Write Below this Line: Office use only:

Blood Test Results: ***TB:***_____

Hep. (ABC)_____

STD'S_____

Date:_____