ELMS COLLEGE

Report of Medical History

Please complete this before going to your physician for examination

I am a: ❑ **campus resident** ❑ **Commuter**

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

Please Print Answers

Last Name (surname) | First Name | Middle Name | Age | Gender

Home Address (No. and Street) | City | State | Zip Code | Country

Marital Status | Birth Date | Birthplace | Home Phone

Name, Relationship, and Address of Emergency contact | Home Phone

Emergency contact Business Address | Emergency Contact Cell Phone Number | Business Phone Number

CARE FOR MINORS: Permission is hereby granted for medical treatment of my minor. Signature_____

Parent/Guardian signature

Family History

	Living or Deceased	Present Age or Age at Death	State of Health or Cause of Death
Father			
Mother			
Siblings M/F			
M/F			
M/F			
M/F			
M/F			
SPOUSE			
CHILDREN M/F			
M/F			
M/F			

Have any of your relatives ever had any of the following?	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Cancer			
Allergy Asthma			
Stroke High Blood Pressure			
Nervous or Mental Illness			
Alcohol/Substance Problem			
Neurologic Disease			

Personal History

Please Answer All Questions *Comment on all positive answers in space below or on the back side of this sheet.*

Have you had?	Yes	No
Scarlet Fever		
Measles		
German Measles		
Mumps		
Chicken Pox		
Malaria		
Mononucleosis		
Meningitis		
Sinusitis		
Recurrent Colds		
Whooping Cough		
Tuberculosis		
Pneumonia		
Surgery		
Appendectomy		
Tonsillectomy		
Other		

Have you had?	Yes	No
Insomnia		
Frequent Anxiety		
Frequent Depression		
Alcohol/Drug Problem		
Headaches/Migraine		
Easy Fatigue		
Eye, Ear, Nose, Throat Trouble		
Anorexia/Bulimia		
Skin Disorder		
Hay Fever, Asthma		
Are you Allergic to:		
Penicillin		
Sulfonamides		
Foods (identify)		
Other		

Have you had?	Yes	No
Pain/Pressure in Chest		
Palpitations		
High or Low Blood Pressure		
Rheumatic Fever or Heart Murmur		
Seizure Disorders		
Diabetes		
Thyroid/Endocrine Disorder		
Kidney Disease		
Disease or Injury of Joints/Bones		
Back Problems		
Tumor, Cancer, Cyst		
Jaundice (Hepatitis)		
Stomach or Intestinal Trouble		

Have you had?	Yes	No
Recent Weight Change		
Anemia/Transfusions		
Dizziness, Fainting		
Weakness, Paralysis		
Serious Head Injury		
Sexually Transmitted Infections		

Menstrual History *(optional)*

Age of onset _____
Interval _____
Duration _____
Cramps/Disability _____
Medication _____
Emotional Reaction _____
History of Irregularity _____
Menopause _____
Contraception/Type _____

	Yes	No
A. Has your physical activity been restricted during the past five years? (Give reasons and durations)		
B. Have you received treatment or counseling for a mental illness, personality or character disorder, or emotional problem? (Give details)		
C. Have you had any illness or injury or been hospitalized other than already noted? (Give details)		
D. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past two years? (Other than routine checkups)		
E. Are you currently taking any medication on a regular basis? (Name and for what?)		

Have you tested positive for COVID-19? (circle one) Yes No

If yes, please indicate the date of the positive test: _____

Student's Signature | Date

Student's I.D. Number

Remarks or Additional Information

(Use back side of sheet, if needed)