Medical History Form

Student Name: _____
Birthdate: ___/___/___ Gender:____ Marital Status:_____ Home Country: _____
Emergency Contact: _____ Cell #: _____
Relationship:_____ Other Phone: _____

FAMILY HISTORY: Immediate Family Medical History

Condition	Y/N	Relationship	Condition	Y/N	Relationship
Arthritis			Heart Disease		
Cancer			Kidney Disease		
Diabetes			Stroke		
Epilepsy			Other		

Personal History: Please comment on all yes answers in comment section or on an additional sheet.

Condition	Y/N	Condition	Y/N	Condition	Y/N	Condition	Y/N
Allergies, seasonal		Diarrhea, frequent		Hernia		Sleep Disturbance	
Anemia		Dizziness/Fainting		High Blood Pressure		Stomach Disorder	
Arthritis		Ear, nose, throat disorder		HIV/AIDS		Strep throat, recurrent	
Asthma, chronic		Eating disorder		Kidney disorder		Surgery	
Asthma, exercise induced		Epilepsy		Malaria		Appendectomy	
Attention Deficit disorder		Eye problem		Menstrual problems		Tonsillectomy	
Back Problem		Fracture/Sprain		Mononucleosis		Thyroid disorder	
Bronchitis, recurrent		Gallbladder disease		Paralysis		Tuberculosis	
Cancer		Head injury		Pneumonia		Tumor/Cyst	
Chickenpox		Headache, recurrent		Rheumatic Fever		Urinary tract infection	
Depression		Heart condition/ Murmur		Sexually Transmitted Infection		Weight gain/loss	
Diabetes		Hepatitis A B C Circle type		Sinus Condition		Other	

Mental Health History:

Condition	Y N	Condition	Y N	Condition	Y N
Psychological/Emotional Disability		Under Psychiatric Care		Mental Illness	
Suicide Ideation/Attempt		Anxiety/Depression		Other	

Disability:

Condition	Y N	Condition	Y N	Condition	Y N
Hearing		Learning		Physical	
Visual		Other		Other	

RECENT HOSPITALIZATIONS: Include date/reason

_____

LIST ALLERGIES TO DRUGS, FOODS, POLLEN, MOLD OTHER:

_____

LIST MEDICATIONS TAKEN REGULARLY:

_____

COMMENTS *Please explain all "yes" answers noted above:*

_____

Consent for Treatment: I hereby grant permission to Palm Beach Atlantic University Stringendo School For Strings personnel, counselors, and representatives to obtain treatment (medical/surgical/emotional) necessary to my health and well being. I also permit hospitalization if indicated, and I understand that the expenses for such treatments and /or hospitalizations shall be my responsibility.

Signature:_ _____ **Date**: _____
Student or Guardian's Signature (if student is under the age of 18)

Relationship _____
Please return form no later than registration day.