



Student Name: _____

Student Address: _____

Marital Status: _____ Occupation: _____

MEDICAL HISTORY

STUDENT HISTORY

(Check those you have had ✓)

- Allergies
- Anemia
- Arthritis
- Chicken Pox
- Diabetes
- Diphtheria
- Drug Flashbacks
- Epilepsy
- Eye Problems
- Fainting Attacks
- Frequent Chest Colds
- Frequent Headaches
- Frequent Head Colds
- Frequent Tonsillitis
- Heart Disease
- High Blood Pressure
- Jaundice
- Kidney/Bladder Disease
- Liver Disease
- Low Blood Pressure
- Malaria
- Military Service Overseas
- Measles
- Mumps

FAMILY HISTORY

(Parents, grandparents, brothers and sisters)

- Pleurisy
- Pneumonia
- Rheumatic Fever
- Scarlet Fever
- Sinus Disease
- Thyroid Disease
- Typhoid Fever
- Tuberculosis
- Venereal Disease
- Weight Loss <10 lbs.
- Whooping Cough
- Allergy
- Arthritis
- Brain Tumors
- Cancer
- Diabetes
- Epilepsy
- Heart Disease
- High Blood Pressure
- Leukemia
- Mental Disease
- Tuberculosis
- Venereal Disease

History of Injuries: If any, give short account. If none, indicate "none." _____

History of Operations. If any, when? What? If none, indicate "none." _____

Have you ever sought psychiatric counsel? Yes No
 If yes, please explain the circumstances. _____

THIS PART TO BE COMPLETED BY YOUR PHYSICIAN

Date: _____
 Height _____ Weight _____ Blood Pressure _____ Temp _____ Pulse _____
 Vision without glasses: Right ____/____ Left ____/____
 Vision with glasses: Right ____/____ Left ____/____
 E.E.N.T. _____
 Heart _____ Extremities _____
 Lungs _____ Reflexes _____
 Abdomen _____ Genitals _____
 Urine: Sugar _____ Albumin _____ Microscopic _____
 TB Tine _____ Chest X-ray, if positive _____
 Serological test for syphilis _____

Does this person seem to be physically capable of being enrolled in school? Yes No

Please list any limitations on the back of this sheet.

Physician's Signature: _____

Physician's Printed Name: _____

Physician's Address: _____