HEALTH HISTORY

(This Page To Be Completed By Student)

Name: _____ Date: _____

Address: _____ Age: _____ Sex: _____ DOB: _____

City/State/Zip: _____

Telephone: _____ Program Applying For: (circle one)

Physician: _____ **Rad Tech** **Pharm Tech** **OTA/PTA**

Hospital of Choice: _____ **EMS** **Nursing** **Surg Tech**

Should any condition change during enrollment, it is your responsibility to notify the department. Answer each of the following questions truthfully. Falsification of information will result in dismissal.

Have you now, or ever had:	Yes	No
Frequent Headaches/Migraines		
Eye, Ear, Nose, Throat Trouble		
Difficulty in Hearing		
Wear Contacts/Glasses		
Sinus Trouble/Frequent Colds		
Asthma/Difficulty Breathing		
Lung Trouble/Pneumonia		
Chest Pains		
Rheumatic Fever		
Heart Disease/ Murmur		
Hepatitis/Jaundice		
Hernia/Rupture		
Excessive Bleeding from Cuts		
Thyroid Disease		

Have you now, or ever had:	Yes	No
Varicose Veins		
Kidney/Bladder Trouble		
Menstrual Trouble		
Foot Trouble		
Sprained/Strained Back/Ruptured Disc		
Arthritis/Painful/Swollen Joints		
Back Trouble/Injury/Unable to lift 50 lbs		
Epilepsy/Fits/Seizures		
Frequent Dizziness/Fainting		
Nervous Breakdown/Memory Loss		
Eating Disorder/Bulimia/Anorexia		
High/Low Blood Sugar/Diabetes		
Take any Prescribed Medication Regularly		
*Allergies/Reactions to Medications/Drugs		

List All Medications Taken Regularly: _____

*Please Specify Any Drug Allergies: _____

Do you have any serious illness/injury not listed above, or do you have any present concern pertaining to your health which may interfere with activities of the health care program to which you are applying? Yes _____ No _____
(If yes, please explain)

In Case of Emergency, Please Notify: Home Phone: _____

_____ Work Phone: _____

Name Relationship

I certify that all of the above information is true and correct to the best of my knowledge.

Date: _____ Signature: _____