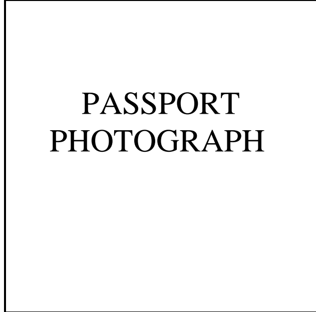

STRICTLY CONFIDENTIAL

HEALTH INFORMATION FORM

The Health Information Form is required for all students. Please carefully complete the form, providing accurate and honest information. This information is strictly confidential, will be used by the Student Life Office, and will not be released without your written consent. Complete Part A. Then take the ENTIRE form to your examining physician for completion of Part B and C. PART A (To be completed by student and parent/guardian)

____

Last Name First Name Middle Name

____

Home Address (number & street) City or Town State Nationality ________________ State of Origin _____________ L.G.A __________________ E-mail:_________________________
BIRTHDATE: Month ______ Day_______ Year _______ Gender: Male ____ Female ____
Marital Status _____________

____

Father's Name Address Phone Number

____

Mother's Name Address Phone Number

____

Whom to notify in case of emergency Address Phone Number

____

Family Physician's Name Address Phone Number Class/Course _________________ School ______________________ Registration number _________________

Office use

PAST MEDICAL CONDITIONS have you ever had any of the following? Please check the appropriate box for all of the conditions on the next page and write an explanation for every "yes" item, in the accompanying space. Use additional sheet if necessary.

Condition	**Yes**	**No**	**Explain yeses**
1. Allergies (food, medicine or others)	Yes	No	…………………………….
2. Chronic or recurrent sinusitis	Yes	No	…………………………….
3. Frequent or prolonged cold	Yes	No	…………………………….
4. Frequent sore throat	Yes	No	…………………………….
5. Chronic cough	Yes	No	…………………………….
6. Asthma	Yes	No	…………………………….
7. Other respiratory problem	Yes	No	…………………………….
8. Frequent or severe earaches	Yes	No	…………………………….
9. Hearing loss	Yes	No	…………………………….
10. Visual problem	Yes	No	…………………………….
11. Glasses contact lens	Yes	No	…………………………….
12. Chronic or severe dizziness	Yes	No	…………………………….
13. Seizure/epilepsy	Yes	No	……………………………
14. High blood pressure	Yes	No	…………………………….
15. Heart condition	Yes	No	…………………………….
16. Rapid or irregular heart beat	Yes	No	…………………………….
17. Frequent or severe chest pain	Yes	No	…………………………….
18. Thyroid problem	Yes	No	…………………………….
19. Diabetes	Yes	No	…………………………….
20. High cholesterol	Yes	No	…………………………….
21. Jaundice	Yes	No	…………………………….
22. Frequent or severe indigestion	Yes	No	…………………………….
23. Gastric or duodenal ulcer	Yes	No	…………………………….
24. Chronic or recurrent diarrhea	Yes	No	…………………………….
25. Rectal Bleeding	Yes	No	…………………………….
26. Genital/gynecological problems	Yes	No	…………………………….
27. Chronic /urinary tract infection	Yes	No	…………………………….
28. Other Kidney problems	Yes	No	…………………………….
29. Psychological/emotional problems	Yes	No	…………………………….
30. Aneamia/blood disorders	Yes	No	…………………………….
31. Chronic/Recurrent skin disorders	Yes	No	…………………………….
32. Arthritis/Rheumatoid disorders	Yes	No	…………………………….
33. Eating Disorder	Yes	No	…………………………….
34. Cancer	Yes	No	…………………………….
35. Others (specify)	Yes	No	…………………………….

SURGICAL HISTORY

Type of Surgery	Year

SERIOUS INJURIES

List serious injuries you have had. Indicate when they happened and any residual disability

Injury Description	Year	Residual Disability

CURRENT MEDICATION(S)

Medicine	Dosage	Condition

ALLERGY

Medicine	Reaction