LAST FIRST M.I.

## C.W. POST CAMPUS OF LONG ISLAND UNIVERSITY REPORT OF MEDICAL HISTORY

## ALL STUDENTS MUST COMPLETE THIS FORM

Student: Please complete this page before going to your physician for examination.

							М	F									
SOCIAL SECURITY NO. / I.D. NO. DATE OF BIRTH							SEX	E-MAIL CELL PHONE NUMBER						IMBER			
HOME ADDRESS (Number & Street) CITY OR TOW						VN		STATE/COUNTRY	ZIP CODE			<u> </u>	HOME TELEPHONE NO.				
NAME & ADDRESS OF EMERGENCY CONTACT RELATIONSHIP						<b>D</b>	HOME TELEPHONE NO.					BUSINESS TELEPHONE NO.					
FAMILY HIS	STORY																
STATE		OF					CAUSE OF	Have any of your relatives had									
		HEAI	ALTH OCCUPATION		DEATH			DEATH				YES	S NO	RELATIO	NSHIP		
Father								Tuberculosis Diabetes									
Mother							_						+				
Brother(s)							-		Kidney Disease Heart Disease								
				<del>                                     </del>			_		Arthritis								
	+						_		Stomach Disease								
Sister(s)							-		Asthma Hay Fever								
									☐ Epilepsy☐ Convulsions		_						
DEDCOMAL	LUCTORY			1						. , _							
PERSONAL HAVE YOU		Voc	No			Vac	N <sub>0</sub>			Voc	No				Voc	No	
		Yes	No	Insomnia		Yes	No	Chest		Yes	No	Gallbladder Trouble			Yes	No	
Scarlet Fever Measles								Pain Pressure		_							
German Measles				Frequent Anxiety Frequent Depression				Chronic Cough			or Gallstones  Recurrent Diarrhea		2				
Mumps				Worry or Nervousness			Palpitations (Heart)	Recurrent Diarries									
Chicken Pox				Recurrent Headaches				High Blood Pressure	Recent Weight:			Поппа					
Malaria				Recurrent Colds				Low Blood Pressure	Gain Loss			Loss					
Gum Tooth Trouble								Rheumatic Fever	☐ Dizziness ☐ Fainting			_					
Sinusitis				Head Injury with Unconsciousness				Heart Murmur	☐ Weakness ☐ Paralysis								
Eye Trouble				☐ Hay Fever ☐ Asthma				Joint Problems:				Convulsions					
☐ Ear ☐ Nose				Tuberculosis				Trick Knee		URINE: Sugar							
☐ Throat Trouble				Shortness of Breath				Shoulder	Albumin								
Surgery				Allergy				Back Problems	Frequent Urination			Jrination					
Appendectomy				Penicillin				☐ Tumor ☐ Cancer ☐ Cy	Cyst Smoker - h			now mar	ny per day:				
Tonsillectomy				Sulfonamides				Jaundice	FEMALES O			ONLY					
Hernia Repair				Serum				Stomach Trouble	Irregular Perio			eriods					
Other				Foods (which)				Intestinal Trouble	Severe Cramps								
				Other				☐ Diabetes ☐ Hypoglyce	mia		E	xcessive	Flow				
									•		·	DETU		UC FORM			
A Heeven	u nhuninal antivitu	haan sa		during the post five veges?		Yes	No	ADDITIONAL COMMENTS						IIS FORM PE PROVID	FD 1	O.	
A Has your physical activity been restricted during the past five years? (Give reasons and duration)												udent Heal					
B Have you had difficulty with school or teachers? (Give details)							Counseling Center C.W. Post Campus										
C Have you received treatment or counseling for a nervous condition, emotional problems, or substance abuse problems? (Give details)						Long Island University 720 Northern Blvd.											
Have you had any illness or injury or been hospitalized other than already noted? (Give details)													N.Y. 11548- 99-4113	1300			
E Have you consulted or been treated by clinics, physicians, healers or other practitioners within the past five years?																	
(Other than routine checkups?)  CHECK IF ANY APPLY:								STUDENT AFFIDAVIT: I hereby certify that all the information entered									
52011	_ Wheelchair be	ound		[	eaf			is complete & accurate	ᠸ.								
	Use of braces	or crute	ches	F	learing im	paired	ı										
Blind Other handi							Student Signature: Dat				Date						
	Bilnd     Visually impai	ired			ulei nanc	arcap		<b>5</b> —									
Di :	, ,								C.W	/. P(	OST (	CAM	PUS	3			
Please brie	eny explain your s	special r	ieeds:					_		Lon	NG ISI	AND					