

UNIVERSITY OF SOUTHERN INDIANA NURSING AND HEALTH PROFESSIONS
REPORT OF MEDICAL HISTORY

TO BE COMPLETED BY APPLICANT AND GIVEN TO EXAMINING PHYSICIAN FOR REVIEW

Name: _____ Social Security # _____

A. Family History:

Has anyone in your family ever been treated for any of the following diseases? If so, who? Include parents, grandparents, brothers, sisters, aunts, and uncles. Answer "Yes" or "No" and give relationship.

	Yes	No	Relationship
Alcoholism _____			
Allergies _____			
Arthritis _____			
Cancer _____			
Diabetes _____			
Heart Disease _____			
Mental Disease _____			
Seizure Disorder _____			
Substance Abuse _____			
Tuberculosis _____			

B. Personal History

1. Age _____ Height _____ Weight _____
2. Have you had any unusual loss/gain of weight in the last year? Yes No
If yes, explain _____

3. Do you wear glasses: Yes No Do you wear contact lens? Yes No
4. Have you ever had any injuries which required medical attention? Yes No If so, specify and give age: _____

5. Have you ever had any surgery? Yes No If so, specify and give age: _____

6. Are you easily fatigued? Yes No Comment: _____

7. Do you take any non-prescription medicines? Yes No If so, please identify those medications: _____

8. Are you presently taking any prescribed medications? Yes No If so, please identify those medications: _____

9. Do you drink alcoholic beverages? Yes No If so, how much weekly? _____
10. Do you smoke? Yes No If so, how much daily? _____
11. Do you have frequent upper respiratory infections? Yes No If so, how frequently? _____
12. Are you under a doctor's care for any condition at this time? Yes No If so, what condition? _____

13. Who is your family physician? Name _____
Address: _____

C. Have you ever had or been treated for any of the following? Please indicate date and present status online provided.

Adrenal Disease _____	Immune System Disorder _____
Alcoholism _____	Indigestion _____
Allergies _____	Insomnia _____
Appendicitis _____	Jaundice _____
Asthma _____	Joint Pain _____
Arthritis _____	Kidney Disease _____
Back Trouble _____	Loss of Weight _____
Blood Disease _____	Malaria _____
Breast Disease _____	Meningitis _____
Breathing Difficulties _____	Mental Illness _____
Bronchitis _____	Mononucleosis _____
Cancer _____	Muscular Weakness of Loss of Control _____
Chickenpox _____	Nervous Disorders _____
Colitis _____	Nosebleeds _____
Constipation _____	Pleurisy _____
Cough _____	Pneumonia _____
Curvature of the Spine _____	Poliomyelitis _____
Dental Problems _____	Poor Hearing _____
Diabetes _____	Poor Vision _____
Diarrhea _____	Psoriasis _____
Dizziness/Fainting _____	Rheumatic Fever _____
Drug Abuse _____	Scarlet Fever _____
Ear Infection _____	Seizures _____
Eczema _____	Sinus Problems _____
Epilepsy/Convulsions _____	Spastic Colon _____
Fast/Irregular Heart Beat _____	Speech Defects _____
Flat Feet _____	Strep Throat _____
Ganglions _____	Swelling of Ankles _____
Gonorrhea _____	Syphilis _____
Gynecological Problems _____	Thyroid Imbalance _____
Hay Fever _____	Tonsillitis _____
Headaches _____	Tuberculosis _____
Heart Disease _____	Typhoid _____
Hepatitis _____	Ulcers _____
Hernia _____	Varicose Veins _____
Herpes Simplex Type II _____	Vomiting _____
High Blood Pressure _____	Warts, Moles, or Corns _____
Hives _____	Other _____
Hoarseness _____	FEMALES ONLY: Date of last PAP smear _____

D. Please list any health problems of concerns _____

Applicants Signature _____

Date _____

Signature of Physician _____

Date _____