Medical History Form

Student Name: ______________________________

Date of Birth: ______________________________

Personal medical history, please print legibly in blue or black ink.

List all allergies (medications, food, insects etc.) and the reactions.

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Do you smoke or use any tobacco products? _____ Do you drink alcohol? ______

Please check any conditions that you have been or are currently being treated for:

❑ ADHD ❑ Alcohol/Drug Dependency ❑ Anemia, Blood Disease ❑ Anxiety/Depression ❑ Arthritis, Joint/Bone Disease ❑ Asperger Syndrome ❑ Asthma ❑ Autism	❑ Bipolar Disorder ❑ Blood Clots, Phlebitis ❑ Cancer ❑ Chicken Pox ❑ Diabetes Type 1 ❑ Diabetes Type 2 ❑ Digestive Disorder ❑ Epilepsy, Seizures ❑ Head Injury ❑ Heart Murmur, Disease ❑ Hepatitis	❑ High Blood Pressure ❑ Hypoglycemia (Low blood sugar) ❑ Lymes Disease ❑ Malaria ❑ Migraines ❑ Rheumatic Fever ❑ Schizophrenia ❑ Thyroid Disease ❑ Tuberculosis
List any other medical condition you have that is not on this list:		

Doctor's Name	**Office Phone Number**	**Specialty**

List Current Medications *Please use back side if needed.*	**Dosage**	**Frequency**

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