

Name _____ Date of Birth _____ NU ID# _____
Last First Middle Initial

Have you had any of the following? Please check the appropriate box.

Heart /Lungs	Yes	No	Orthopedics	Yes	No	Tonsillectomy		
Asthma			Arthritis			Wisdom Teeth Extraction		
Heart Disease			Fractures (History of)			Previous Hospitalizations		
Heart Murmur			Skin	Yes	No	Infectious Diseases	Yes	No
High Blood Pressure			Eczema			Chicken Pox		
Pneumonia			Psoriasis			Hepatitis Type: _____		
Rheumatic Fever/Rheumatic Heart Disease			Hives			HIV Infection		
Thrombophlebitis (Blood Clots)			Hematology/Oncology	Yes	No	Infectious Mononucleosis (Mono)		
			Anemia			Malaria		
Endocrine	Yes	No	Blood Disorders			Mumps		
Adrenal Disorders			Cancer			Tuberculosis		
Diabetes			Radiation Therapy			Typhoid Fever		
Thyroid Disorders			Neurological	Yes	No	Sexually Transmitted Diseases		
Kidney	Yes	No	Convulsions			Carrier of Infectious Diseases (History)		
Kidney or Bladder Disease			Head Injury			Social History	Yes	No
Kidney Transplant			Headaches			Do you smoke or use smokeless tobacco?		
			Multiple Sclerosis					
Ears/Eyes/Nose/Throat	Yes	No	Muscular Dystrophy			Do you drink alcohol?		
Eye Disorders (other than glasses or contacts)			Stroke/TIA			Do you take drugs?		
Hearing Loss			CAPS	Yes	No	Do you exercise regularly?		
Nasal Allergies (Hayfever)			Anorexia (Eating Disorder)			Do you take herbal medicines?		
Sinus Infections			Bulimia (Eating Disorder)			Do you take vitamins?		
			Depression			OB History (enter #)		
Stomach/Bowel	Yes	No	ADD			Pregnancies _____ Miscarriages _____		
Chronic Colitis			Surgical History/Hospitalizations	Yes	No	Live Births _____ Now Living _____		
Gallbladder Disease			Prior Surgery _____			Abortions _____ Still Born _____		
Ulcers			Appendectomy			Current medications (include birth control pills, acne meds, etc.):		
Irritable Bowel Syndrome			Ear Tubes					
Jaundice (other than newborn)			Gallbladder Removal					
Liver, Stomach, or Bowel Disease			Knee ACL Repair <input type="checkbox"/> Left <input type="checkbox"/> Right			Please list medication allergies:		
			Knee Arthroscopy <input type="checkbox"/> Left <input type="checkbox"/> Right					
Peptic Ulcer			Ovarian Cyst Removal			Have you had any reactions to bee stings, dyes, food, latex, etc.? If so, what were your symptoms?		

Comment on all "yes" answers:
Any other health issues:

Does your immediate family have any of the following? Please check the appropriate box.

	Mother	Father	Siblings	Maternal Family	Paternal Family
Alcoholism					
Diabetes					
Cancer (List Type)					
Heart Disease					
High Cholesterol					
Kidney Disease					
High Blood Pressure					
Stroke					
Other (Please explain)					