

# 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.

MIDDLE

FIRST NAME

LAST NAME (print)

M F	M	F	
SOCIAL SECURITY NO.	DATE OF BIRTH	SEX	E-MAIL
CELL PHONE NUMBER	HOME ADDRESS (Number & Street)		CITY OR TOWN
STATE/COUNTRY	ZIP CODE	HOME TELEPHONE NO.	
NAME & ADDRESS OF EMERGENCY CONTACT		RELATIONSHIP	BUSINESS TELEPHONE NO.

**FAMILY HISTORY**

	AGE	STATE OF HEALTH	OCCUPATION	AGE OF DEATH	CAUSE OF DEATH
Father					
Mother					
Brother(s)					
Sister(s)					

**Have any of your relatives had any of the following?**

	YES	NO	RELATIONSHIP
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Arthritis			
Stomach Disease			
<input type="checkbox"/> Asthma <input type="checkbox"/> Hay Fever			
<input type="checkbox"/> Epilepsy <input type="checkbox"/> Convulsions			

**PERSONAL HISTORY**

HAVE YOU HAD:	Yes	No		Yes	No		Yes	No	Yes	No	
Scarlet Fever			Insomnia			<b>Chest</b>			Gallbladder Trouble		
Measles			Frequent Anxiety			<input type="checkbox"/> Pain <input type="checkbox"/> Pressure			or Gallstones		
German Measles			Frequent Depression			Chronic Cough			Recurrent Diarrhea		
Mumps			Worry or Nervousness			Palpitations (Heart)			<input type="checkbox"/> Rupture <input type="checkbox"/> Hernia		
Chicken Pox			Recurrent Headaches			High Blood Pressure			Recent Weight:		
Malaria			Recurrent Colds			Low Blood Pressure			<input type="checkbox"/> Gain <input type="checkbox"/> Loss		
<input type="checkbox"/> Gum <input type="checkbox"/> Tooth Trouble			Head Injury with Unconsciousness			Rheumatic Fever			<input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting		
Sinusitis						Heart Murmur			<input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis		
Eye Trouble			<input type="checkbox"/> Hay Fever <input type="checkbox"/> Asthma			Joint Problems:			<input type="checkbox"/> Epilepsy <input type="checkbox"/> Convulsions		
<input type="checkbox"/> Ear <input type="checkbox"/> Nose			Tuberculosis			Trick Knee			URINE: Sugar		
<input type="checkbox"/> Throat Trouble			Shortness of Breath			Shoulder			Albumin		
<b>Surgery</b>			<b>Allergy</b>			Back Problems			Frequent Urination		
Appendectomy			Penicillin			<input type="checkbox"/> Tumor <input type="checkbox"/> Cancer <input type="checkbox"/> Cyst			Smoker - how many per day:		
Tonsillectomy			Sulfonamides			Jaundice			<b>FEMALES ONLY</b>		
Hernia Repair			Serum			Stomach Trouble			Irregular Periods		
Other			Foods (which)			Intestinal Trouble			Severe Cramps		
			Other			<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypoglycemia			Excessive Flow		

	Yes	No
A Has your physical activity been restricted during the past five years? (Give reasons and duration)		
B Have you had difficulty with school or teachers? (Give details)		
C Have you received treatment or counseling for a nervous condition, emotional problems, or substance abuse problems? (Give details)		
D Have you had any illness or injury or been hospitalized other than already noted? (Give details)		
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:

<input type="checkbox"/> Wheelchair bound	<input type="checkbox"/> Deaf
<input type="checkbox"/> Use of braces or crutches	<input type="checkbox"/> Hearing impaired
<input type="checkbox"/> Blind	<input type="checkbox"/> Other handicap
<input type="checkbox"/> Visually impaired	

Please briefly explain your special needs: \_\_\_\_\_

**ADDITIONAL COMMENTS**

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**RETURN THIS FORM IN ENVELOPE PROVIDED TO:  
Director, Student Health and Counseling Center  
C.W. Post Campus  
Long Island University  
720 Northern Blvd.  
Brookville, N.Y. 11548-1300  
FAX: (516) 299-4113**

**C.W. POST CAMPUS**

