

Have you ever had or been treated for any of the following?

Please write “Y” for yes and leave “blank” for no.

MEDICAL HEALTH HISTORY

Scarlet Fever		Sinusitis		Tumor, growth, cyst, cancer		Females Only:	
Measles (rubeola)		Eye Trouble		Hemorrhoids		Been treated for a female disorder	
German Measles (rubella)		Ear, nose, throat trouble		Kidney stone or blood in urine		Had severe cramps	
Mumps		Frequent or severe headaches		Diagnosis of albumin or sugar in urine		Other menstrual problems	
Chicken Pox		Dizziness or fainting spells		STI-Syphilis, gonorrhea, etc.		Date of last period	
Malaria		Retinal detachment		Arthritis, rheumatism or bursitis		Date of last Pap Smear	
Tuberculosis		Hearing loss		Bone, joint or other deformity		If sexually active, type of birth control	
Mononucleosis		Chronic or frequent colds		Recurrent back pain		Pill	
Surgery:		Severe tooth or gum trouble		“Trick” or locked knee?		IUD	
Appendectomy		Hay fever		Neuritis		Barrier	
Tonsillectomy		Skin disease		Paralysis (including partial)		Other	
Hernia Repair		Thyroid trouble		Epilepsy or seizures		Are you pregnant now?	
Other:		Asthma		High cholesterol		# of pregnancies	
Allergy to:		Shortness of breath		Jaundice or hepatitis		# of miscarriages	
Drugs		Pain or pressure in chest		Frequent indigestion		# of abortions	
Pollens/Foods		Chronic cough		Depression		# of live births	
Insect bites		Heart trouble		Excessive worry or panic attacks		Briefly describe any items you answered YES.	
Do you use regularly:		Rapid or irregular heartbeat		Excessive dieting and/or excessive exercise			
Prescription Rx?		Ankle swelling		Frequent trouble sleeping			
Over the Counter Rx?		Varicose veins		Other psychological or emotional disorders			
Other drugs		High or low blood pressure		Emotional, verbal or physical abuse			
Periods of unconsciousness		Gall bladder trouble or stones		Sexual abuse			
Loss of memory or amnesia		Recurrent constipation or diarrhea		Drug, tobacco or alcohol abuse			

In the event of an emergency 911 will be called and we will notify your emergency contact.

In case of illness and/or injury, permission is granted to treat the above named student at Student Health & Counseling Services, Cal State San Marcos and to make the necessary referrals to outside Physicians and Facilities if necessary.

Student's Signature

Date

Parent's Signature (if student is a minor)

Date