

# REPORT OF MEDICAL HISTORY

## CENTENARY COLLEGE OF LOUISIANA

To the Student: YOU HAVE BEEN ACCEPTED. Information you provide will not be used to influence your situation at the College; it will be used solely as an aid to providing necessary health care while you are a student. This information is strictly for the use of the Health Services and will not be released to anyone without your knowledge and consent. **PLEASE COMPLETE THIS BEFORE GOING TO YOUR PHYSICIAN FOR EXAMINATION.**

Name (print)

\_\_\_\_\_

Last

First

Middle/Complete

Social Security No.

Home Address \_\_\_\_\_

City

State

Zip

Telephone No.

Date of Birth \_\_\_\_\_  Male  Female Marital Status \_\_\_\_\_

Class you are entering:  Freshman  Sophomore  Junior  Senior Previously enrolled here?  Yes  No

Proposed Date of Registration:  Fall  Spring  Summer 20\_\_\_\_

Emergency Contact: \_\_\_\_\_

Name

Relationship

Address

Telephone Number

### FAMILY HISTORY Have any of your relatives ever had any of the following?

	Age	State of Health	Occupation	Age/Cause of Death	Yes	No	Relationship
Father							
Mother							
Brothers							
Sisters							

  

	Yes	No	Relationship
Diabetes			
Heart Disease, Stroke			
Cancer			
Asthma, Allergies			
Tuberculosis			
Alcohol/drug problem			
Depression			

### PERSONAL HISTORY Please answer all questions.

Have you had:	Yes	No	Have you had:	Yes	No
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	Ear, nose	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	throat trouble	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
More than 10 lb	<input type="checkbox"/>	<input type="checkbox"/>	Food/drug allergy	<input type="checkbox"/>	<input type="checkbox"/>
weight gain or			Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
loss in past year			Sulfa	<input type="checkbox"/>	<input type="checkbox"/>
Females:			Severe allergies	<input type="checkbox"/>	<input type="checkbox"/>
menstrual	<input type="checkbox"/>	<input type="checkbox"/>	requiring Epipen		
problems			Please list all allergies:		
			_____		
			_____		

### Please comment on all positive answers.

Have you had:	Yes	No	Have you had:	Yes	No
Head injury or	<input type="checkbox"/>	<input type="checkbox"/>	Disease or injury	<input type="checkbox"/>	<input type="checkbox"/>
concussion	<input type="checkbox"/>	<input type="checkbox"/>	of joints		
Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Back problems	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety or	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or	<input type="checkbox"/>	<input type="checkbox"/>
depression	<input type="checkbox"/>	<input type="checkbox"/>	intestinal problem	<input type="checkbox"/>	<input type="checkbox"/>
Sleep difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Liver or Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	problem	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/drug	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, cancer	<input type="checkbox"/>	<input type="checkbox"/>
problem	<input type="checkbox"/>	<input type="checkbox"/>	or cyst	<input type="checkbox"/>	<input type="checkbox"/>
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Do you drink alcohol?		
Do you smoke cigarettes or use smokeless tobacco?		
Do you take any medications on a regular basis? (List)		
Has your physical activity been restricted during the past five years? (Give details)		
Have you received treatment or counseling for alcohol or drug abuse, an eating disorder, depression or any other emotional problem? (Give details) Have you been hospitalized or received in-patient care for any of the above-mentioned conditions?		
Have you had any significant illness or injury for which you have been treated or hospitalized other than already noted? (Give details)		
Do you have any question in regard to your health, family history, or other matters?		

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

Physician's Signature (Acknowledging Review) \_\_\_\_\_

Date \_\_\_\_\_



OFFICE OF HEALTH SERVICES  
CENTENARY COLLEGE OF LOUISIANA

PHONE (318) 869-5671  
2911 CENTENARY BOULEVARD

FAX (318) 841-7235  
SHREVEPORT, LA 71104