# BROOKLYN CAMPUS/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) — MAJOR

| STUDENT IDENTIFICATION NO. | DATE OF BIRTH | SEX M F | E-MAIL | CELL PHONE # |
|---|---|---|---|---|

| HOME ADDRESS (Number & Street) | CITY OR TOWN | STATE/COUNTRY | ZIP CODE | HOME TELEPHONE NO |
|---|---|---|---|---|

| NAME & ADDRESS OF EMERGENCY CONTACT | RELATIONSHIP | HOME TELEPHONE NO. | 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 | | | |
| ☐ Asthma ☐ Hay Fever | | | |
| ☐ Epilepsy ☐ Convulsions | | | |

**PERSONAL HISTORY**

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

_________ Wheelchair bound

_________ Use of braces or crutches

_________ Blind

_________ Visually impaired

_________ Deaf

_________ Hearing impaired

_________ Other handicap

Please briefly explain your special needs: ______________________

______________________

**ADDITIONAL COMMENTS**

**RETURN THIS FORM**
**IN ENVELOPE PROVIDED TO:**
**Health Services Department**
**Brooklyn Campus**
**Long Island University**
**175 Willoughby Street**
**Brooklyn, NY 11201**

Student's Signature ______________________ Date

Physician's Signature ______________________ Date

BROOKLYN CAMPUS

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