STUDENT HEALTH NEEDS/ALLERGIES

All questions contained in this questionnaire are strictly confidential
(Please us N/A if not applicable)

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**

HEALTH HISTORY

Immunizations	☐ Tetanus	Please attach a copy of your immunization records	☐ Pneumonia
	☐ Hepatitis		☐ Chickenpox
	☐ Influenza		☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

List your prescribed medications including medication taken at home

Name the Medication	Strength	Frequency Taken

Allergies to medications or foods

Type of allergy	Reaction You Had	How you control reactions

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐	Skin	☐	Chest/Heart
☐	Head/Neck	☐	Back
☐	Ears	☐	Intestinal
☐	Nose	☐	Bladder
☐	Throat	☐	Bowel