

Medical History / Health Update

Please complete all information. Please print clearly. Black or blue ink only.

Legal Name _____
Last Name First Name Middle Name Suffix (Jr., etc.)

Preferred Name, if not first name (choose only one) _____ **Former last name(s)**, if any _____

Program of Study _____

Date of Birth _____ **Social Security No.** _____

Home Phone (_____) _____ **Cell Phone** (_____) _____

Current Address _____
Number and Street City State Zip Code

The purpose of the questions obtained in this medical history is to secure complete information regarding the condition of the examinee's health. All injuries, illnesses and health conditions must be stated and fully explained. Information obtained will be kept in the Student health file and treated as a confidential medical record. **Please answer all questions below.**

Please review your program clinical standards. These standards are required by Mercy College students. (For a complete listing of standards refer to the College Catalog or the Program Clinical Standards Form.)

Allergies: Medication/Environmental/Latex (If none, state "none")	Current Medications (If none, state "none")

Do you have or been treated within the last 10 years for any of the following? If yes, please comment in space below.

	Yes	No		Yes	No		Yes	No
1. Surgery, Accident and/or injury			16. Kidney disease, stones or difficulty w/urination			30. Are you currently under a physician's care other than routine visits		
2. Cancer			17. Goiter or Thyroid Disease			31. Skin Disease		
3. HIV/AIDS			18. Dizziness/Weakness			32. Have you ever had an EMG, MRI, CT Scan or other diagnostic studies		
4. Liver disease / Infectious Hepatitis			19. Numbness or tingling in wrists or hands			33. Examined by a psychiatrist, orthopedist or any other specialist		
5. Leukemia/Blood Disease			20. Any mental disorder				34. Have you ever used illegal drugs and/or abused prescription drugs	
6. Diabetes			21. Epilepsy, convulsions, or seizures			35. How much do you drink per week? Beer _____ Wine _____ Liquor _____		
7. Asthma or wheezing			22. Diseases of muscle or bone				36. Have you ever participated in a Substance Abuse Program	
8. Cough, Pleurisy, Lung Disease			23. Headaches/Migraines			37. Have you ever had a positive TB skin test		
9. Chest pain, pressure, or shortness of breath			24. Disease, swelling or pain in joints				38. Have you ever taken TB medication	
10. Heart "trouble"			25. Back trouble or scoliosis			39. Have you ever had chicken pox in your lifetime		
11. High or Low Blood Pressure			26. Ulcers of the stomach					
12. Swelling of feet or ankles			27. Blood in bowel movement or black stool					
13. Diseases of the eye			28. Hernia					
14. Defective color vision			29. Any other diseases, disabilities, abnormalities, conditions or on-going health concerns					
15. Impaired hearing or ringing in the ears								

If you answered YES to any of the above questions please record question number and explain (include dates and description of event(s)):

I have read, understood and answered all questions on the medical history inquiry form. I understand that any deception or knowingly false statements I make in completing this form may result in dismissal from my educational program.

Student Signature: _____ **Date:** _____