RHODES MEDICAL HISTORY FORM

This form is to be completed and signed by the incoming student or parent by JUNE 1
All forms must be in English

Scan and email form to Health-forms@rhodes.edu by June 1

Student's Name_______ Birthdate_____ Rhodes ID_____

FAMILY MEDICAL HISTORY

Indicate any items that apply to your parents, siblings or grandparent.

Disease	Family Member	Disease	Family Member
High Blood Pressure		Diabetes	
Bleeding tendency		Heart Disease	
Anemia		Tuberculosis	
Sickle Cell Anemia		HIV	
Mental Illness		Seizures	
Cancer		Depression	
ADD/ADHD		Thyroid	

CURRENT MEDICATIONS

List any antibiotics, antidepressants, birth control pills, inhalers, vitamins, minerals and any herbal/natural product (prescription and nonprescription) that you currently use and how often you use them.

Name	Dose	Frequency	Use

HOSPITALIZATIONS/SURGERIES

List date and reason for any hospitalizations or surgeries:

Date	Reason	Comments

ALLERGIES

Indicate any allergies and reactions you experience to:

Medications_____
Environmental_____
Food_____
Are you allergic to latex? Yes____ No____
"I do not have any known allergies." If this is correct, please initial here _____

SOCIAL HISTORY

Indicate if you use any of the following:

Cigarettes/Cigars/Dip Yes____ No____ Pack of Amount per Day _____
Alcohol Yes____ No____ Drinks per Week_____
Caffeine Yes____ No____ Cups per Day_____

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PERSONAL HISTORY

Indicate the presence or absences of a personal history of all of the following. If you answer yes to any of these items, please indicate the approximate year in which they occurred.

Disease	History	Year	Disease	History	Year	Disease	History	Year
Anemia	Y / N		Tuberculosis	Y / N		Recurrent Urinary Infections	Y / N	
Bleeding Tendency	Y / N		Bronchitis	Y / N		Mumps	Y / N	
Phlebitis/Blood Clots	Y / N		Pneumonia	Y / N		Measles	Y / N	
High Blood Pressure	Y / N		Sickle Cell Anemia	Y / N		German Measles	Y / N	
Thyroid Problems	Y / N		Depression	Y / N		Cancer Type:_____	Y / N	
Hypoglycemia	Y / N		Mental Illness Type:_____	Y / N		Menstrual Irregularities	Y / N	
Diabetes	Y / N		Epilepsy/Seizures	Y / N		Hernia	Y / N	
Chicken Pox/Shingles	Y / N		Neurological Disorders	Y / N		Skin Problems Type:_____	Y / N	
Strep Throat	Y / N		Vision Problems/Glasses	Y / N		Ulcers/Stomach/ Intestinal Problems	Y / N	
Mononucleosis	Y / N		Eating Disorder	Y / N		Back Problems Type:_____	Y / N	
Sinus Problems	Y / N		Concussion/Head Injury	Y / N		Orthopedic Issues Type:_____	Y / N	
Allergies/Hay Fever	Y / N		Headaches/Migraines	Y / N		Rheumatic Fever	Y / N	
Asthma	Y / N		Hearing Problems	Y / N		Other:	Y / N	
Depression	Y / N		ADD/ADHD	Y/ N				

Student Signature: _____ Date: _____