PART A - Continued

Name: _____

Social Security No.: _____

Check at right of each item. If "yes," explain as appropriate. Use back of sheet if necessary. All Items require a "yes" or "no" response.

**** Please call Clark University Health Services if local provider referral information is needed at 508-793-7467 ****

	YES	NO
PAST ILLNESSES:		
1. Hospitalization (date, reason)		
2. Operation (date, type)		
3. Serious accident		
4. Serious illness		
5. Emotional problem		
6. Psychiatric treatment		
7. Other significant health problems (specify)		
COMMUNICABLE DISEASES - GIVE DATE:		
8. Chicken pox		
9. Malaria		
10. Tuberculosis		
11. Other (specify)		
ALLERGIES:		
12. Penicillin		
13. Other antibiotics (name)		
14. Other medications		
15. Life threatening reaction to insect bites, food, etc.		
16. Do you carry an epinephrine kit?		
DO YOU CURRENTLY TAKE:		
17. Heart/blood pressure medications		
18. Psychiatric meds/antidepressants		
19. Insulin		
20. Allergy injections (see information sheet)		
LIFESTYLE:		
21. Alcohol (ounces per week)		
22. Cigarettes per day? Years smoking?		
23. Do you diet frequently?		
24. Do you exercise regularly?		
25. Do you wear a seatbelt?		
26. Special diet restriction? (specify)		
HAVE YOU EVER HAD:		
27. Migraines (diagnosed by MD)		
28. Epilepsy/convulsion		
29. Paralysis or disability		
30. Thyroid problems		
31. High blood pressure		
32. Rheumatic fever		
33. Heart murmur (diagnosed by MD)		
34. Mitral valve prolapse		

	YES	NO
HAVE YOU EVER HAD (cont.):		
35. Asthma		
36. Colitis/ileitis		
37. Irritable Bowel		
38. Hepatitis		
39. Kidney disease		
40. Back problems		
41. Eating disorder (type)		
42. High cholesterol (number)		
43. Mono (diagnosed by MD)		
44. Diabetes		
45. Exposure to Estrogen (DES) before birth		
CURRENT HEALTH PROBLEMS:		
46. Are you currently under treatment for any psychological problem? **If yes, the following is required:** Diagnosis: _____ Medication: _____ Psychiatrist Name: _____ Psychiatrist Phone: _____ Counselor Name: _____ Counselor Phone: _____		
47. Do you have a chronic disease? If yes, list diagnosis:		
48. Physical disability (type)		
49. Learning disability		
50. Visual impairment (describe)		
51. Hearing loss/Hearing aid		
52. Crutches, braces or other prosthesis		
53. Loss of paired organ (i.e., one eye, one kidney, etc.) Which organ? Which side?		
54. Are you presently under treatment for any medical problem? If yes, describe:		
55. **LIST** Medications you expect to be continuing when You enter Clark.		