AMERICAN JEWISH UNIVERSITY

Initial Health History

(To be completed by student. All information is confidential.)

Last name:	First name:	Gender: [ ] Female [ ] Male
Student ID:	Date of birth:	Local phone:
Local address:		
City	State: Zip:	Permanent phone:

In case of emergency, notify:	Relationship:
Phone	Address:

A. Family Background: Has anyone in your immediate family or blood relatives had any of the following?

	Yes	No	Explanation
High blood pressure			
Thyroid disease			
Sickle cell anemia			
Stroke or heart attack before age 50			
Cancer			
Women: Breast cancer			
Woman: Cervical or ovarian cancer			

B. Personal History

	Yes	No	If yes, please specify.
Are you currently under the care of a physician?			
Do you have any allergies, including allergies to any medications?			
Do you smoke?			(How many per day?)
Do you drink alcohol?			(How much per week?)
Do you consider yourself overweight?			(How much?)
Do you have or have you ever had anorexia or bulimia?			
Do you exercise regularly?			(What type & how often?)
Have you ever had a sexually transmitted infection?			

C. Have you ever had or do you have any of the following?

	Yes	No	Explanation & dates
Alcohol and / or drug problem			
Anemia			
Asthma or hay fever			
Bladder infections, recurrent			
Blood clot or vein problem			
	Yes	No	Explanation & dates
Cancer			Specify type:
Chest pain or lung problem			
Diabetes			
Digestive / abdominal problem / ulcer			

cont. on back

	Yes	No	Explanation & dates
Eye disease			
Fainting or dizzy spells			
Gynecological disorders or surgeries			
Headaches			
Headaches, migraine (diagnosed)			
Hearing loss / ear aches			
Heart murmur or other heart problem			
Hepatitis, jaundice, liver problem			
High blood pressure			
Kidney disease			
Recurrent anxiety, significant depression, other emotional illness			
Seizures or epilepsy			
Sleep problem			
Surgery			Specify type:
Thyroid problem			
Tuberculosis			
Any other significant surgery or surgical conditions? Please provide information you feel will be pertinent to your care.			
Women: Do you have annual gynecological exams with pap smears?			Date & result of recent exam:
Have you ever been pregnant?			Date & outcomes:
Are your periods regular?			At what age did you start to menstruate: How frequent? How many days do they last? Date of the first day of your last menstrual period:

Consent: This must be signed by the student, and, for minors (under 18 years of age), by parent or legal guardian. Authority and consent is given to American Jewish University to cause the examination and treatment of the above named student either at the Student Health Center or by outside physicians and medical facilities as are available in case of illness and/or injury as well as University Health Requirements. Consent is further given for necessary admission to and medical or surgical treatment in a hospital. It is agreed that all medical and/or hospital expenses incurred beyond those covered by any applicable student insurance policy will be paid directly by the undersigned student and parent or guardian and the University will not be responsible thereon. Consent is also given to release health requirement information for clinical placements to respective departments and/or clinical sites.

Date & Signature	
Date:	Student:
If under 18, date:	If under 18, Parent / Legal Guardian:

Return completed form to the Student Health Center or the Office of Student Affairs on the Familian Campus.