CLARK ATLANTA UNIVERSITY
Student Health Center
Report of Medical History

Name (Last, First,Middle) | Last Four of SSN | 900 Number

Local Address | Area code & Phone #

Date of Birth | Age | Sex | Marital Status | Country of Citizenship

/ / | | Male / Female | [ ] Single [ ]Married [ ]Other

Home Address (Number and Street or R.R., City, State Zip) - If different from above | Area code & Phone #

Emergency Contact (Name, Relationship, Address) | Home Telephone Number

Business Address | Business Telephone

ALL INFORMATION IS TREATED CONFIDENTIALLY AND NOT RELEASED WITHOUT STUDENT CONSENT

PERSONAL HISTORY: PLEASE ANSWER ALL QUESTIONS. Additional comments can be written in the spaces below.

Have you had or have you now any of the following?

	Yes	Year	No
Measles			
German Measles, Rubella			
Mumps			
Chicken Pox			
Epilepsy, Convulsions			
Eye trouble			
Ear, Nose, Throat			
Tuberculosis			
Surgery: List below			
Insomnia			
Frequency Anxiety			
Frequent Depression			
Worry or Nervousness			
Recurrent Headaches			
Recurrent Colds			
Head Injury with Unconsciousness			
Asthma, Hay Fever			
Shortness of Breath			
Allergy			
Penicillin			
Sulfonamides			
Serum			
Foods			
Others: List			
Pain/Pressure in Chest			
Chronic cough			
High Blood Pressure			

	Yes	Year	No
Rheumatic Fever or Heart Murmur			
Heart Disease			
Disease/ Injury of Joints, Back			
Tumor, Cancer, Cyst			
Stomach or Intestinal Trouble			
Gallbladder Trouble of Gallstones			
Recurrent Diarrhea			
Rupture, Hernia			
Recent Gain or Loss of Weight			
Dizzy Spells, Fainting			
Weakness, Paralysis			
Venereal Disease			
Albumin/ Sugar in Urine, Diabetes			
Kidney Disease			
Frequent Urination			
Inf.Mononucleosis			
Inf. Hepatitis			
Other Medications:			
List any Medications:			

FEMALES ONLY:	Yes	No
Irregular Periods		
Severe Cramps		
Excessive Flow		
Date of last Pap Smear		
Results:		

FALL / SPRING