MEDICAL HISTORY

NOTE TO THE APPLICANT: This form must be completed by you and your physician. Admission can not take place until this form is completed, received and approved. Corrective treatment and immunization should be done before admission to the School of Medicine

NAME (Please Print) SOCIAL SECURITY NUMBER

____ ____________/______________/_________________

Last First Middle Initial

PERMANENT ADDRESS TELEPHONE NUMBER

____ ( ) _______________________________

Street City & State Zip Code Area Code Number

DATE OF BIRTH BIRTHPLACE

______________________________ ____

Month Day Year City State County

SEX MARITAL STATUS DEPENDENTS (Y or N) _______ RELIGION

_________________________ _______________________ _________________________ ____________________

(M OR F) (M) (S) (D) Other If yes, age(s)

MOTHER'S MAIDEN NAME ____

FATHER OR GAURDIAN'S NAME ____

ADDRESS ____

Street City & State

NEAREST OF KIN: ____

Last First Middle Initial

Address ____

Street City & State Zip Code

RELATIONSHIP ____________________________________ TELEPHONE NUMBER ( ) _________________

WHICH OF THE FOLLOWING DISEASE HAVE YOU HAD? Insert year.

Measles___________________	Asthma_____________________	Joint difficulty________________	Pneumonia____________________________
Mumps ___________________	Arthritis ____________________	Hernia ______________________	Tuberculosis __________________________
Whooping cough ___________	Poliomyelitis ________________	Kidney disease _______________	Jaundice ______________________________
Chicken pox ______________	Rheumatic fever ______________	Nervous breakdown ___________	Peptic ulcer ___________________________
Diphtheria _______________	Heart disease _________________	Typhoid fever ________________	Hay fever _____________________________
Rubella __________________			

IF YOU ARE OR HAVE BEEN UNDER A PHYSICIANS CARE for other than minor illnesses, please describe and have physician send medical data

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ARE REQUIRED TO TAKE PRESCRIBED MEDICATION? (Yes or No) ______________ If Yes, What Medication (s) _____________________

____

I CERTIFY THAT THE ANSWERS TO THE QUESTIONS ABOVE ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE ____________________ SIGNATURE ____

(Applicant)

SIGNED ____

(By Parent or Guardian, If Applicant Under 21)

FORM WILL BE RETURNED IF INCOMPLETE OR LACKING PROPER SIGNATURE