MEDICAL HISTORY FORM
Ulster Project – Arlington Version

Name_____
(last) (first) (middle)

Address_____

Phone_____ Date of Birth *(MM/DD/YY)* _____

Parents/Guardian Names_____

1. Check the childhood diseases you have had:

q Chicken Pox q Measles q Scarlet Fever

q Whooping Cough q Mumps q German Measles

2. Illnesses/medical visits (includes counseling) in the last 6 months:_____

_____

3. Infections

q Appendicitis q Hepatitis q Pneumonia

q Poliomyelitis q Rheumatic Fever q Tuberculosis

4. Chronic Disorders/Conditions

q Digestive q Hearing q Heart q Glandular q Mental
q Muscular q Visionq Nervous System q Skin q Nose & Throat
q Asthma q Epilepsy q Diabetes q Other

Please give detailed information regarding ANY of the above ailments you have had, dates, lasting effects, medicine or treatment now required. (Please use the reverse)

5. Hospitalization or surgery in the last 5 years q YES q NO
If yes, please give details_____

6. Normal Blood Pressure _____ Normal Pulse _____

7. Fill in Immunization Dates q Polio_____ q Tuberculosis_____

q Tetanus, Toxin & Booster_____

8. Medication you need to bring along: _____

9. Known Allergies: q Medicines _____

q Food_____ q Animals _____

q Other_____

10. Family Physician's Name: _____

Phone Number: _____

Parents/Guardian's Signature: _____ Date_____