# AURAK STUDENT HEALTH HISTORY FORM

*(Student Life Office)*

**Name:** _____ **ID Number:** _____ **Date:** _____

**Date of Birth (DD/MM/YY):** _____ **Nationality:** _____ **Gender:** _____

**Mobile Number: (____)** _____ **Email Address:** _____

**Height:** _____ **Weight:** _____ **Blood Type:** _____

***For the following questions, encircle your answers, whichever applies. Your answers are for our records and will be kept confidential in Student File, Student Life Office and AURAK Health Center.***

## MEDICAL HISTORY

1. Are you currently in good health? . . . . . YES NO
2. Has there been any change in your general health within past year? . . . . . YES NO
3. Are you under treatment of any physician now? . . . . . YES NO

   If so, please specify the condition and treatment: _____

4. Do you have or have you had any of the following diseases/disorders/problems:

| | | | | | |
|---|---|---|---|---|---|
| **a. Migraine** | YES | NO | **k. Anemia** | YES | NO |
| **b. Neurological Problem If YES, specify:_____** | YES | NO | **l. Cardiovascular Disease If YES, specify:_____** | YES | NO |
| **c. Diabetes If YES, which type:_____** | YES | NO | **m. Jaundice, Hepatitis, Liver Disease** | YES | NO |
| **d. Kidney Problem** | YES | NO | **n. Asthma** | YES | NO |
| **e. Hearing Problem** | YES | NO | **o. Seizures** | YES | NO |
| **f. Back Problem** | YES | NO | **p. Vision Problems** | YES | NO |
| **g. Malaria** | YES | NO | **q. Tuberculosis** | YES | NO |
| **h. Chickenpox** | YES | NO | **r. Measles** | YES | NO |
| **i. Thyroid Problem** | YES | NO | **s. Stomach/Gastric Problem** | YES | NO |
| **j. Psychological Problem** | YES | NO | **t. Anxiety Problem** | YES | NO |

5. Have you had abnormal bleeding? . . . . . YES NO
6. Have you ever required a blood transfusion? . . . . . YES NO
7. Have you had any serious problem associated with any dental treatment? .... YES NO
8. Do you have any disease/condition not listed above that you think we should know about? . . . . . YES NO

   If YES, specify: _____

9. Are you wearing contact lenses? . . . . . YES NO

10. Are you wearing dental prosthetics? . . . . . YES NO

## SOCIAL HISTORY

1. Marital Status : __Single __Married __Separated __Divorced __Widowed

2. Use of Tobacco: __Never __Previously but Quit __Daily (_____: pack per day)

## MEDICATION

Are you taking any medicine, including non-prescription medications? . . . . . YES NO

If YES, specify:

| Name of Medication | Indication | Dosage & Timings |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

## ALLERGY

Please indicate if you have known allergies to the following:

1. Medications. . . . . YES NO
   If YES, specify which particular medicine: _____
2. Foods. . . . . YES NO
   If YES, specify which particular food: _____
3. Environmental Factors (pollens, dust, wasp stings). . . YES NO
   If YES, specify: _____

## PREVIOUS HOSPITALIZATION

| Date | Procedure/Surgery | Name of Hospital |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

***Physician Name, Signature, Stamp:*** _____

***Date MM/DD/YY:*** _____

_____

***Received by Student Life Office:***

_____ _____

***Student Life Office*** ***Date***