## STUDENT HEALTH FORM

### STUDENT INFORMATION

<table>
<thead>
<tr>
<th>Student Name (First, Middle Initial, Last)</th>
<th>Program Entering (please check one)</th>
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<tbody>
<tr>
<td></td>
<td>MD</td>
</tr>
<tr>
<td></td>
<td>Clinical Research</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Local Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<table>
<thead>
<tr>
<th>Telephone Number</th>
<th>Email</th>
<th>Birthplace</th>
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<tbody>
<tr>
<td>HOME</td>
<td>CELL</td>
<td></td>
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</tbody>
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### EMERGENCY CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
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<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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### PRIMARY CARE INFORMATION

<table>
<thead>
<tr>
<th>Primary Care Provider</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<tr>
<th>Specialists (name and phone)</th>
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### MEDICAL HISTORY

#### FAMILY HISTORY

- Family member with disease

- Asthma

- Tuberculosis

- Diabetes

- Heart Disease

- Hypertension

- Kidney Disease

- Cancer, type

- Rheumatologic Disease, type

- Other, describe
### Medical History, Continued

#### PERSONAL HISTORY
(check all that apply)

- Sinus Infections
- Ear Infections
- Eye Problems
- Recurrent Colds
- Asthma
- Allergies
- Chronic Cough
- Chest Pain
- Palpitations
- Shortness of Breath
- Tuberculosis or Positive PPD
- High Blood Pressure
- Heart Murmur
- Thyroid Disease
- Diabetes
- High Cholesterol
- Gallbladder Disease
- Hepatitis
- Chronic Diarrhea
- Constipation
- Peptic Ulcer
- Celiac Disease
- Urinary Tract Infections
- Kidney Disease
- Head Injury
- Headaches
- Dizziness / Fainting
- Seizures
- Paralysis
- Hearing Problems
- Speech Problems
- Joint Pain
- Gout
- Back Pain
- Anemia
- Sickle Trait / Disease
- Thalassemia Trait / Disease
- Weight Gain / Loss
- Insomnia
- Anxiety
- Depression
- Irregular menses
- Severe Cramps
- Breast Mass
- Other: 

#### Additional Information

**Please answer the following questions:**

Has your education or work been interrupted due to a medical reason in the past two years? 

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**Medications** (include over-the-counter drugs, vitamins, alternative medicines, insulin and contraceptive) Specify dosage: 

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**Hospitalizations and surgeries** (include year and reason): 

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**Allergies** (include medication, food and environmental allergens): 

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