HEALTH HISTORY FORM

UNIVERSITY of MOBILE
SCHOOL OF NURSING

NAME LAST FIRST MI	BIRTHDATE	SEX	RACE
ADDRESS	CITY	STATE	ZIP
HOME TELEPHONE ( )	EMERGENCY CONTACT #1 (Name and Phone Number)		
CELL TELEPHONE ( )	EMERGENCY CONTACT #2 (Name and Phone Number)		

Section I:

Do you have a present or past medical history of any of the following medical conditions?

Please check YES or NO.

Alcohol addiction/dependency	YES☐ NO☐	Diabetes	YES☐ NO☐	Lung infections	YES☐ NO☐
Anemia or blood disorder	YES☐ NO☐	Drug addiction/dependency	YES☐ NO☐	Measles	YES☐ NO☐
Anorexia Nervosa	YES☐ NO☐	Ears or nose problems	YES☐ NO☐	Mumps	YES☐ NO☐
Anxiety/tendency to worry	YES☐ NO☐	Epilepsy or seizures	YES☐ NO☐	Non-malignant tumors	YES☐ NO☐
Arthritis	YES☐ NO☐	Eye problems	YES☐ NO☐	Pregnancy	YES☐ NO☐
Asthma	YES☐ NO☐	Fainting, Dizziness	YES☐ NO☐	Psychiatric illness	YES☐ NO☐

Back problems	YES☐ NO☐	Gallbladder trouble	YES☐ NO☐	Rapid heat beat	YES☐ NO☐
Bladder or kidney infections	YES☐ NO☐	Gynecological problems	YES☐ NO☐	Recurrent diarrhea	YES☐ NO☐
Blindness	YES☐ NO☐	Headaches	YES☐ NO☐	Sexually transmitted diseases	YES☐ NO☐
Blood clots	YES☐ NO☐	Hearing loss	YES☐ NO☐	Skin problems	YES☐ NO☐
Bone or joint problems	YES☐ NO☐	Heart murmur	YES☐ NO☐	Sinus problems	YES☐ NO☐
Cancer or malignancy	YES☐ NO☐	Hepatitis	YES☐ NO☐	Strep throat	YES☐ NO☐
Chest pain	YES☐ NO☐	High blood pressure	YES☐ NO☐	Thyroid disease	YES☐ NO☐
Chicken Pox	YES☐ NO☐	Hypoglycemia	YES☐ NO☐	TMJ	YES☐ NO☐
Colitis/enteritis	YES☐ NO☐	Infectious mononucleosis	YES☐ NO☐	Tuberculosis	YES☐ NO☐
Congenital/birth defects	YES☐ NO☐	Kidney stones	YES☐ NO☐	Ulcers	YES☐ NO☐
Depression	YES☐ NO☐	Liver disease, Jaundice	YES☐ NO☐	Varicose veins	YES☐ NO☐

Explanation(s) of any medical condition/disorder that was identified by "Yes". Please be specific.

Is there any significant medical history or physical/mental condition that could affect your functioning as a nursing student, including interaction with patients/clients and staff in clinical or institutional settings?

YES☐ NO☐ Please describe.

Are you currently taking any medication that could affect your participation in a nursing education program, including interaction with patients/clients and staff in clinical or institutional settings? yes☐ NO☐ Please describe:

Section II:

Do you have any allergies? YES☐ NO☐ (Specify)

Medications:

Foods:

Insects:

Latex: YES☐ NO☐

Section III:

Please complete the record below if you take any medications (prescription or non-prescription) on a regular or routine basis

NAME OF MEDICATION	DOSAGE	REASON PRESCRIBED

Section IV: Statement and Consent

I hereby give, to the Dean of the University of Mobile, School of Nursing, or his designee, permission to release information regarding my health status to appropriate persons within the School of Nursing or clinical agencies. I understand that this information is to be used for educational purposes only. I certify that this information is true and correct and I have no abnormality, limitation, or restriction other than those identified in this document. I understand that any false information, willful or negligent misrepresentation, or failure to disclose any requested information, will constitute sufficient grounds for dismissal from the University of Mobile, School of Nursing and prohibit readmission in the future. I agree to notify the Dean of the School of Nursing concerning any changes in my physical or mental health while I am enrolled and a student in the School of Nursing. I acknowledge by my signature that I have read these statements and will be compliant. My signature also acknowledges that I have read the Core Performance Standards for non-licensed students for Clinical Course Work in the School of Nursing and am able to undertake all aspects of the nursing education program.

Student Signature _____ Date_____

Healthcare Provider Signature _____Date_____