



Family Health History Report

This form must be completed, signed and returned to complete your NJC student admission file. All information you provide will be submitted to the Student Health Office on campus and is confidential. Information on this form may not be released without your written permission.

Personal Information:

Name:
 Last _____ First _____ MI _____ Social Security _____
 Birth date _____ Age _____ Place of Birth (City, State, Country) _____
 Sex (circle one): Male Female Marital Status (Circle One): Single Married Other Phone # _____
 Year and Semester You Plan to Enroll _____ Major/Field of Study _____

Permanent/Mailing Address:
 Number/Street _____
 City _____ State _____ Zip _____ Country _____

Emergency Contact:
 Name _____ Relationship _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Business Phone _____ Alternate Phone _____

Personal Health History: Please check box with an X if your answer is Yes, leave blank if the answer is No

<input type="checkbox"/> Recurrent Headache	<input type="checkbox"/> Pain/Pressure in Chest	<input type="checkbox"/> Anemia	Allergies: <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa Drugs <input type="checkbox"/> Serum, Vaccines <input type="checkbox"/> Foods <input type="checkbox"/> Other Please list any prescribed or over the counter medication used regularly: _____ _____ _____
<input type="checkbox"/> Head injury w/unconsciousness	<input type="checkbox"/> High or Low Blood Pressure	<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Epilepsy, Convulsions	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Urinary Infection	
<input type="checkbox"/> Dizziness, Fainting	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Migraines	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Trick knee/shoulder	
<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Stomach or Intestinal Trouble	<input type="checkbox"/> Back Problems	
<input type="checkbox"/> Gum or tooth trouble	<input type="checkbox"/> Gallbladder or Gallstones	<input type="checkbox"/> Weakness, Paralysis	
<input type="checkbox"/> Eye trouble (vision)	<input type="checkbox"/> Recurrent Diarrhea	<input type="checkbox"/> Skin Disease	
<input type="checkbox"/> Recurrent Colds	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Insomnia	
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Frequent Depression	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tumor, cancer or cyst	<input type="checkbox"/> Worry or nervousness	Surgery: _____ _____ _____
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Rupture/hernia	<input type="checkbox"/> Appendectomy	
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Recent weight gain or loss	<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Palpitations (heart)	<input type="checkbox"/> Thyroid Disease		

Family Health History of Student:					
Family Member	Birth Date	State of Health	Occupation	Age at Death	Cause of Death
Father:					
Mother:					
Brother(s):					
Sister(s):					
Children:					

Have any of your relatives ever had any of the following:

Yes	Relationship and Explanation
<input type="checkbox"/> Hypertension	_____
<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Epilepsy	_____
<input type="checkbox"/> Convulsions	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Emotional Problems	_____
<input type="checkbox"/> Drug or Alcohol Problems	_____

CONSENT FOR MEDICAL TREATMENT**

In case of illness and/or accident, I grant permission to Northeastern Junior College Student Health Center nurse practitioner to obtain medical information, examine, and render minor medical services. I further agree to abide with the decisions of said Student Health Center when, in the Director's judgment, it is deemed advisable that I be referred to a physician, dentist, and/or hospital for such treatment as any illness and/or accident may necessitate. My choice of physician, dentist, and/or hospital will be honored by the Health Center whenever possible, but when circumstances do not permit same, said Health Center will be allowed to obtain proper and adequate medical care as is most expedient. I request that my consent be given before my parents are notified of any serious illness of any major surgical procedure, except when a delay might vitally endanger my health.

Date: _____ **Signature:** _____

Birth date: _____

****Religious Waiver:** If you are an active member of a religious group which prohibits medical treatment, we request no signature to the above statement. Please sign below if you wish to waive medical treatment because of religion.

Date: _____ **Signature:** _____

Optional: Family Physician or Specialist:

Name

Address Phone Number Fax Number

All information you provide is confidential and may not be released without your written permission.