Maryland Institute College of Art
CONFIDENTIAL
1300 Mount Royal Avenue
Baltimore, Maryland 21217-4191

Date_____

Health History must be completed.
This is mandatory for all students.

Personal Information

Please answer all questions. This information is strictly for the use of the Student Health Services and will not be released to anyone without your knowledge and consent.

Last Name | First Name | Middle

Social Security Number | Date of Birth | Marital Status | Sex: F M

Home Address (number and street) | City or Town | State | Zip Code

Home Telephone Number | Cell Phone Number

Next of Kin's Name, Address and Relationship | Home Telephone

Next of Kin's Business Address | Business Telephone

Personal History: Part I

Question	Yes	No	If you select yes, please provide details.
Have you had surgery? (For example, appendectomy, tonsillectomy, hernia repair, etc.)			
Do you take medication, pills, or use other drugs regularly?			
Are you allergic to any medicine?			
Do you have allergies to food, insects, stings, or other materials?			
Do you have any handicap which requires assistance in evacuation in case of an emergency in a classroom or other space?			
Have you received treatment or counseling for stress, nervous condition, personality or character disorder, or emotional problems?			

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Personal History: Part II

Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No
Eczema			Shortness of breath			Vomiting		
Acne			Asthma			Recurrent constipation		
Head injury with unconsciousness			Chronic cough			Recent weight gain		
Tumor, cancer, or cyst			Cystic fibrosis			Recent weight loss		
Dizziness or fainting			Chest pain			Hernia		
Eye trouble			Palpitations (heart)			Hemorrhoids		
Ear problem			Rheumatic fever			Do you drink alcohol?		
Hearing difficulty			Heart murmur			Do you use street drugs?		
Nose problem			High blood pressure			Back problems		
Sinusitis			Low blood pressure			Disease or injury of joints		
Hayfever			Anemia			Bladder infection		
Gum or tooth trouble			Sickle cell			Kidney infection		
Throat problem			Bleeding disorder			Weakness or paralysis		
Neck injury			Stomach trouble			Seizures		
Do you smoke?			Intestine trouble			Recurrent headaches		
Bronchitis			Gall bladder trouble			Insomnia		
Do you use marijuana?			Jaundice			Frequent anxiety		
Pneumonia			Hepatitis			Frequent depression		
Tuberculosis			Recurrent diarrhea			Worry or nervousness		
Mononucleosis			Malaria			Sports enhancing drugs		
Sexually transmitted disease			Diabetes			Thyroid problem		
Herpes								
Females only								
Irregular periods			Severe cramps			Excessive flow		
Abnormal pap			Pregnancy			Cystic breasts		
Males only								
Prostate problems			Lump or mass in testicle					

Health Insurance Information

If you have any type of health insurance or HMO, specify details.

Company or Organization

Address | City or Town | State | Zip Code

Policy or contract Number | Expiration Date

NOTE: It is required that all undergraduate students have accident insurance. A policy is available through the College.

Please complete and return to: Maryland Institute College of Art Office of Student Affairs 410.225.2422

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Family History

Parent History					
Parent	Age	Health	Occupation	Age of Death	Cause of Death
Mother					
Father					

Number of brothers_____ Number of sisters_____

Family Illness History - Have any of your blood relatives ever had any of the following?			
Affliction	Yes	No	Relationship
Bleeding disorder			
Tuberculosis			
Diabetes			
Kidney disease			
Arthritis			
Stomach disease			
Asthma			
Hayfever			
Heart attack/disease			
Epilepsy			
Convulsions			
Cancer			
High blood pressure			
Stroke			
Suicide			
Alcoholism/addiction			
Hyperlipidemia			
High cholesterol			

Did your mother take DES while pregnant with you?_____

Signature

The signature below indicates that this form has been completed truthfully to the best of the student's knowledge.

_____
Student Signature Date

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Physical Examination

This portion should be completed by a physician.

Name | Age | Height | Weight

Blood Pressure | Urine – Sugar | Urine – Albumin

Vision: Right 20/ Left 20/ Circle one: With correction Without correction

Immunization Requirements

1. Please indicate dates of all immunizations.
2. Documentation of Tetanus/Diphtheria, and immunity to measles and rubella is MANDATORY.
3. If born before 1957 you are considered immune to measles, mumps and rubella.
4. All students must document a TB test and if positive, a chest X-ray within a year.
5. If you are living in campus housing, you are required to either show proof of having had a meningitis vaccination, or waive the vaccination. (see attached information)

Immunization Dates

Immunization		First Shot Date	Second Shot Date	Notes
Rubella (measles), Mumps Rubella (German Measles)	} MMR			To be valid, second MMR must be after 1980.
Polio				Childhood series and boster
Diptheria, tetanus, pertussis				Childhood series
Tetanus/diptheria, tetanus booster				Tetanus is required within 10 years
TB test* or chest x-ray				*Documented TB skin test
Meningitis				

System Abnormalities

System	Yes	No
Head, ears, nose, or throat		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Eyes		
Genitourinary		
Musculoskeletal		
Metabolic/endocrine		
Neuropsychiatric		
Skin		

Are there any abnormalities of the systems listed on the left? Describe.

Your recommendations regarding the care of this student would be appreciated.

Is the student now under treatment for any medical or emotional condition?

Physician's Name | Physician's Signature | Date

Address | City/Town | State | Zip Code

Telephone | Fax

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