



Student's Name: _____

Date of Birth: _____

ALLERGIES TO MEDICATIONS: (Please List)

CONFIDENTIAL ASSESSMENT OF FAMILY HEALTH HISTORY

To the best of your knowledge, does anyone in your family have a history of any of the following conditions? If yes, state which family member has the medical problem.

| | Yes | No | Comments (Indicate Which Family Member) |
|--|-----|----|--|
| Asthma | | | |
| Cancer | | | |
| Heart Disease (heart attack before age 50) | | | |
| Elevated Cholesterol | | | |
| Depression, or other Mental Illness | | | |
| High Blood Pressure | | | |
| Kidney Disease | | | |
| Diabetes | | | |
| Substance Abuse/Alcoholism | | | |
| Tuberculosis | | | |
| Other (describe) | | | |

PARENT/GUARDIAN SIGNATURE: _____ **Date:** _____