Imperial Valley College - *Student Health Center*

HISTORY FORM

The information you provide in this statement will be used to assess your medical qualifications to participate in the Imperial Valley College approved programs. Please complete the history form carefully and thoroughly. All information will be kept confidential.

NAME:______________________________ **DOB:**________________ **G#:**__________________

MEDICAL HISTORY:

Please answer the following. Circle YES or NO or N/A (NOT APPICABLE) on each question – EXPLAIN – TYPE (where applicable)

Do you have or have you ever had any of the following?

Yes	No	Diabetes Mellitus	Yes	No	Musculoskeletal/Arthritis/Injury
Yes	No	High Blood Pressure	Yes	No	Neurological problems
Yes	No	Asthma/Allergies	Yes	No	Psychiatric Disease
Yes	No	High Cholesterol			Type: ________________________
Yes	No	Heart Disease - Type:__________________ Special Testing: __________________	Yes	No	Other List:________________________

Current Medications or Supplements: ☐ **NONE** ☐ **YES, LIST MEDICATIONS (below)**

1.________________________ **3.** ________________________

2.________________________ **4.** ________________________

Other medication(s):

____

____

Allergies: ☐**NONE** ☐**YES, LIST ALLERGIES (below)**

Yes	NO	**Will you be able to lift 35 pounds?**	**Reason if No?**
Yes	NO	**Are you Medically or Physically Disabled?**	**Reason if Yes?**

SURGICAL HISTORY:

☐ **NO** ☐ **Yes** **(if yes explain below)**

____ Date: ________________

____ Date: ________________

____ Date: ________________

SOCIAL HISTORY:

Tobacco: ☐Current ☐Past ☐N/A How Much?____________________

Alcohol: ☐Current ☐Past ☐N/A How Much?____________________

Drugs: ☐Current ☐Past ☐N/A How Much?____________________

EXERCISE – Type ?: __________________

____

How often ?: ________________________

FAMILY HISTORY: Circle Yes or No – Which 'Family Member'?

Yes	No	Diabetes Mellitus – Type:	Yes	No	High Cholesterol
Yes	No	High Blood Pressure	Yes	No	Heart Disease – Type: **(write below)**
Yes	No	Stroke	Yes	No	Psychiatric Disease – Type: **(write below)**

Additional comments/Information:

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I hereby certify that all statements made in this 'History' form are accurate and complete.

____________________ ____________________________ ______________

Print Name **Signature** **Date**