

STONE LABORATORY

The Ohio State University's Island Campus on Lake Erie

2008 MEDICAL HISTORY FORM

Last Name _____ First Name _____
Home Address _____ City _____ State _____ ZIP _____
Date of Birth ____ / ____ / ____ Age ____ Sex: Male ____ or Female ____ Emergency Contact _____
Country of Origin U.S. / Other _____ Phone# of Emergency Contact (____) _____

Personal History: Do you have or have you been treated for any of the following? (*Please check*)

<input type="checkbox"/> Acne	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Measles (Rubella)	<input type="checkbox"/> Seizure Disorder	Surgical Operations For: <input type="checkbox"/> Appendectomy <input type="checkbox"/> Back Injury <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Broken Bone(s) <input type="checkbox"/> Cosmetic Surgery <input type="checkbox"/> Gynecological Surgery <input type="checkbox"/> Hernia <input type="checkbox"/> Mole Removal <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Orthopedic Surgery <input type="checkbox"/> Pilonidal Cyst <input type="checkbox"/> Tonsils/Adenoids
<input type="checkbox"/> Anemia	<input type="checkbox"/> Drug Dependency	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Sinusitis	
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Eating Disorder (Anorexia/Bulimia)	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Sexually Transmitted Disease	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emotional/Mental Illness	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Systemic Lupus	
<input type="checkbox"/> Asthma	<input type="checkbox"/> German Measles (Rubella)	<input type="checkbox"/> Mumps	<input type="checkbox"/> Thyroid Disorder	
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Tonsillitis	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hearing Disorder	<input type="checkbox"/> Obesity	<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Peptic Ulcer	<input type="checkbox"/> Urinary Tract Infection	
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Pelvic infection	<input type="checkbox"/> Viral Hepatitis	
<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Weight Control (Laxatives)	
<input type="checkbox"/> Chronic Kidney condition	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Polio	<input type="checkbox"/> Worry/Nervousness	
<input type="checkbox"/> Colitis	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Prostatitis	<input type="checkbox"/> Irregular/Painful Menstrual Cycles	
<input type="checkbox"/> Depression	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Psoriasis	Other _____	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Recurrent Headaches	_____	
<input type="checkbox"/> Digestive Disorder	<input type="checkbox"/> Malaria	<input type="checkbox"/> Rheumatic Fever	_____	

Have you ever been hospitalized? Yes No. If yes, explain:

Do you have any physical limitations or permanent disability? Yes No. If yes, explain:

Allergies: Are you allergic to any of the following?

Aspirin	Yes	No
Ampicillin	Yes	No
Penicillin	Yes	No
Sulfa	Yes	No

Other Medication:

List any other allergies, bee sting, food, other:

Family History: Have any of your family members had the following?
(*Please Check*)

	PARENTS	OTHER RELATIVE
Arthritis	_____	_____
Anemia	_____	_____
Asthma	_____	_____
Alcoholism	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
Drug Addiction	_____	_____
Emotional/Mental Illness	_____	_____
Heart Disease	_____	_____
Kidney Disease	_____	_____
Stroke	_____	_____

Medication Usage: Which of the following do you take on a regular basis?
(*Explain*)

<input type="checkbox"/> Antihistamines	<input type="checkbox"/> Ibuprofen
<input type="checkbox"/> Antacid	<input type="checkbox"/> Insulin
<input type="checkbox"/> Arthritis Medication	<input type="checkbox"/> Iron
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Laxative
<input type="checkbox"/> Asthma medication	<input type="checkbox"/> Nasal Spray
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Pain Medication
<input type="checkbox"/> Antidepressant	<input type="checkbox"/> Sleeping Pills
<input type="checkbox"/> Birth Control Pills/IUD	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Cortisone Inhaler	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Digitalis	<input type="checkbox"/> Tranquilizers
<input type="checkbox"/> Diuretic	<input type="checkbox"/> *Other
<input type="checkbox"/> Epilepsy Medication	

*Name and dosage of medication(s)

Miscellaneous Information

	OFTEN	SOMETIMES	NEVER
Do you smoke cigarettes?	_____	_____	_____
Do you use snuff or chew tobacco?	_____	_____	_____
Do you drink alcohol?	_____	_____	_____

Complete, sign and return this with your *Medical Consent* form.

Signature _____ Date _____

(PARENTS OF HIGH SCHOOL STUDENTS MUST SIGN.)