

Mercy College of Northwest Ohio Health Survey



NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

PHONE NUMBER: (____) _____ SOCIAL SECURITY #: _____

To be completed by student: Please check appropriate box. If yes, give date.

	No	Yes		No	Yes
Cancer			Polio		
Anemia			Mononucleosis		
Kidney disease			Back pain or injury		
Urinary tract infection			Curvature of the spine		
Diabetes			Acne or skin disorder		
Heart disease			Epilepsy		
Rheumatic fever			Asthma		
Stomach problems			Hay fever		
Bowel problems			Frequent headaches		
Joint pain/arthritis			Eating disorder		
Nervous condition			Hepatitis		
Emotional problems			Hearing loss		
Frequent sore throats			Pneumonia		
High blood pressure			Thyroid condition		
Head injury			Episodes of fainting		
Hernia			Multiple sclerosis		
Amputation of digit or limb			Hemophilia		
Loss of sight (either eye)			Vascular disease		
Typhoid fever			Other		

If you responded yes to any of the above, please describe: _____

Please list allergies: _____

List current therapy and/or medications: _____

Have you ever had a positive skin test for tuberculosis? Yes _____ No _____

Is there a history of cancer, diabetes, hypertension, heart disease, tuberculosis, or kidney problems in your family? If yes, please explain: _____

