Hackensack Meridian
JFK University Medical Center
Muhlenberg
Harold B. and Dorothy A. Snyder
Schools of Nursing and Medical Imaging

STUDENT NAME: _____ **Date:** _____
Date of Birth: _____ **Telephone (cell) #:** _____
ALLERGIES (If none, document none): _____
Specific allergy needs: _____

PERSONAL MEDICAL HISTORY

PAST HISTORY **Applicant MUST answer all questions, if YES, please explain:**

Have you ever consulted or been treated by a doctor For:	YES or No	**Explain if Yes**
Brain or Nerve Disease, Dizzy Spells, Epilepsy, Severe Headaches , Unconsciousness, Paralysis, Nervous Breakdown or Mental Disorder.		
Lung disease		
Tuberculosis		
Blood Disease, Anemia, or Varicose Veins		
Heart Disease		
Blood Pressure (High or Low)		
Ulcers, Indigestion, Rectal Disease , Hernia, Gall Bladder Disease, Jaundice , Hemorrhoids		
Kidney Disease, Bladder or Prostate Disease		
Arthritis, Allergy, Skin Disease , Syphilis , or Gonorrhea		
Latex Allergy		
Cancer, Tumor, Thyroid Disease or Diabetes		
Eye or Ear Disease		
Back Trouble		
Anv Surgical Operations		
Any Accidents		
Breast Disease, Miscarriage or Female Disorder		
Are you pregnant now?		
Have you ever received payment or benefits for illness, or injury?		
Any present ailments?		

Have you had any illness, injury or hospitalizations other than already noted? Details: _____
_____
_____

Are you currently under treatment by a physician? Please give date of treatment and reason: _____
_____
_____

Do you take any medication? Please list all medications and dosages including over-the-counter medications and reason for taking:_
_____
_____
_____

Do you have any physical limitations that may require assistance in performing the clinical duties required in this program? If YES, please explain specific physical needs: _____
_____
_____

I certify that the above statements are true to the best of my knowledge.

Student's Signature: _____ Date: _____