



**Mercy College - St. Elizabeth Campus**  
**Student Health Services Health History Questionnaire**

NAME: \_\_\_\_\_ SSN: \_\_\_\_\_ DATE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 PHONE: ( ) \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_  
 DEPARTMENT: \_\_\_\_\_  
 PERSONAL PHYSICIAN/PROVIDER: \_\_\_\_\_

**PERSONAL HEALTH HISTORY**

Have you ever had, or do you have, any of the following? If **YES**, please explain in space provided at the end of this questionnaire.

		YES	NO			YES	NO
1.	Skin problems/chronic rash				31.	Broken bones	
2.	Eye problems				32.	Bone or joint problems	
3.	Wear glasses/contacts				33.	Arthritis/gout	
4.	Hearing loss/ear trouble				34.	Neck pain/injury	
5.	Frequent colds				35.	Back pain/injury	
6.	Allergies (list allergies to drugs & environment on next page)				36.	Sciatica or disc problem	
7.	Chronic Cough				37.	Numbness or tingling in legs/feet	
8.	Asthma				38.	Knee injury	
9.	Lung diseases/silicosis, TB				39.	Foot problems	
10.	Shortness of breath/wheezing				40.	Severe/unusual headaches	
11.	Palpitations/chest pain				41.	Dizziness or fainting spells	
12.	Heart trouble/heart attack				42.	Head injury/Epilepsy/seizures	
13.	High blood pressure				43.	Severe weakness or tiredness	
14.	Stroke or paralysis				44.	Depression or anxiety	
15.	Stomach/duodenal ulcer				45.	Emotional or nervous problems	
16.	Yellow jaundice				46.	Bruising of unknown cause	
17.	Liver trouble/hepatitis				47.	Immune suppression	
18.	Recurrent or persistent diarrhea				48.	Blood disease	
19.	Weight problems/changes				49.	Tumors/cancer	
20.	Kidney/bladder trouble				50.	Anemia	
21.	Diabetes/thyroid trouble				51.	Have you had or received a vaccine against:	
22.	Herpes simplex or zoster				a.	Whooping cough	
23.	Hernia/rupture				b.	Diphtheria	
24.	Alcohol/drug problem				c.	Chickenpox	
25.	Varicose veins/Phlebitis				d.	Scarlet Fever / Rheumatic Fever	
26.	Shoulder/elbow/hand pain				e.	Tuberculosis	

27.	Carpal tunnel syndrome				f.	Mumps			
28.	Tendinitis				g.	Measles Rubella (yes / no) Rubeola (yes / no)			
29.	Numbness or tingling in arms/ hands					measles vaccine received: <b>(circle one)</b> none 1 <sup>st</sup> dose                      2 <sup>nd</sup> dose			
30.	Dislocation of joints				h.	Hepatitis B Vaccination Dates Received:			
52.	Have you had any recent contact with a person having an infectious or communicable disease								
53.	Are you currently under a physician's care for any reason								
54.	Have you ever been hospitalized or had an operation								
55.	Have you ever had:								
a.	needle-stick, blood or body fluid exposure								
b.	rash or symptoms related to glove use?								
c.	pain, numbness, or tingling related to repeated hand/wrist motions or keyboard use?								
56.	Please list the date and reason for your last medical examination (Use space provided below)								
57.	Have you had any illness or injury since your last medical examination?								
58.	Have you ever had a reaction, allergy and/or sensitivity to drugs, food, plants, animals, latex, gloves or any other substance?								
Please use lines below to explain any questions below to which you answer "yes"									
59.	Do you exercise regularly? (What type of exercise and how often?)								
60.	Do you smoke or use tobacco? (How long have you smoked and how many packs per day do you smoke?)								
61.	Have you ever quit smoking? (When did you quit, how long did you smoke and how many packs per day did you smoke?)								
62.	Do you drink alcohol? (If yes, how many glasses per week of each beer, wine, liquor)								

PLEASE DESCRIBE ALL "YES" ANSWERS BELOW. PLEASE USE NUMBER WHEN ANSWERING QUESTIONS

**LIST ALLERGIES:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

63. What medicines do you regularly or frequently take? (Include over the counter and prescription medications you have taken in the last three (3) weeks.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

64. TUBERCULOSIS (TB) HISTORY:

Date of last Mantoux PPD/TB skin test: \_\_\_\_\_ Was there a reaction? yes no

Are you known to test PPD/TB positive? yes no

Have you ever taken INH or other preventive medications? yes no

(If yes, which medications: \_\_\_\_\_ when \_\_\_\_\_)

Have you ever had BCG Vaccination? yes no (If yes, when \_\_\_\_\_ where \_\_\_\_\_)

Date of last chest x-ray: \_\_\_\_\_ Results \_\_\_\_\_

Have you had exposures to TB patients while you were not wearing respiratory protection? yes no

I certify that to the best of my knowledge the statements concerning my medical history are true and I understand that any misrepresentation is sufficient cause for dismissal.

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Signature \_\_\_\_\_ Date \_\_\_\_\_

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Witness \_\_\_\_\_ Date \_\_\_\_\_