IU contemporary dance program
summer intensive for high school students

CONFIDENTIAL
HEALTH HISTORY QUESTIONNAIRE

Please answer every question below as best you can. This will help us to give you the best possible medical care. If the space provided to answer questions is not adequate, attach sheet with additional information. Note: PLEASE PRINT.

Name: _____

(last or family) (first) (middle/maiden) Sex: F __ M __

Date of Birth: _____ Home Phone #: _____

Home Address: _____

(street) (city) (state) (zip)

Height _____ Weight_____

IN CASE OF EMERGENCY, PERSON TO NOTIFY:

Name: _____ Relationship _____ Home Phone #: _____

Business Phone #: _____

Home Address _____

("same" if same as above) (city) (state) (zip)

INSURANCE: Do you have health insurance? Yes ____ No ____ Company Name: _____

HOME PHYSICIAN, HEALTH CLINIC OR FACILITY:

Name: _____ Phone #: _____

Address: _____

(street) (city) (state) (zip)

IMMUNIZATIONS: MMR: Date of Dose 1 _____ Date of Dose 2 _____

Tetanus: Date of most recent _____

Have you had an initial series of 3 polio vaccines: yes ____ no ____ Most recent booster: _____

Have you ever had a TB skin test: yes ____ no ____ If yes, result: _____ Date of most recent: _____

Meningitis vaccine: Date _____

Have you completed the hepatitis B vaccine series? ____

Have you had: chickenpox vaccine? ____ chickenpox disease? ____

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Please check in the appropriate column indicating health problems you have had.

	Yes	No		Yes	No
Anemia	___	___	Anxiety	___	___
Bladder Infections	___	___	Bleeding Disorder	___	___
Blood Clot in Lung	___	___	Cancer/Tumor/ Leukemia	___	___
Chest Pain	___	___	Deafness/Hearing Loss	___	___
Depression	___	___	Ear Problems	___	___
Eating Disorder	___	___	Eye Problems	___	___
Fainting Spells	___	___	German Measles	___	___
Headaches	___	___	Head Injury	___	___
Heart Attack	___	___	Heart Disease	___	___
Heart Rhythm Problem	___	___	Hepatitis/Jaundice	___	___
High Blood Pressure	___	___	Hyperventilation	___	___
Insomnia	___	___	Kidney Disease/Stones	___	___
Malaria	___	___	Measles	___	___
Mononucleosis	___	___	Mumps	___	___
Neck/Back Problems	___	___	Obesity	___	___
Phlebitis	___	___	Pregnancy	___	___
Prostatitis	___	___	Rheumatic Fever	___	___
Sickle Cell Anemia	___	___	Skin Problems	___	___
Speech Disability	___	___	Stroke	___	___
Suicide Attempt/Act	___	___	Tuberculosis Exposure/ or Disease	___	___
Ulcer	___	___			

Other Medical Problems Not Listed Above:

_____

_____

_____

_____

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Give a brief statement of your general health ____

If you check yes to any questions below, describe problems in detail.

	YES	NO	Details of Medical History
1. Do you have any current medical problems?	____	____	
2. Are you taking any prescription or over-the-counter medications, nutritional or dietary supplements, herbs... on a regular basis? (List all substances, dosages, and reasons for taking.)	____	____	
3. Are you allergic to any medications? If yes, what? What is your reaction?	____	____	
4. Does your health prevent you from participating in any physical activities?	____	____	
5. Have you had any chronic illnesses, serious illnesses or physical disabilities?	____	____	
6. Have you had any surgeries or been hospitalized for any reason? (Describe and give approximate dates.)	____	____	
7. Do you have asthma? (If so, has the condition been stable for a year?)	____	____	
8. Are you allergic to dust, molds, pollens, insect stings, foods? If yes, explain severity and means of treatment.	____	____	
11. Do you have or have you had seizures? (Describe type of seizure, severity, and frequency.) List medications and dosages taken for seizures. Give date of last seizure.	____	____	
12. Do you have diabetes, thyroid trouble or other endocrine problems?	____	____	
13. Have you ever been under the care of a psychologist, psychiatrist, or counselor? If yes, when ______________ for what reason __________________________________	____	____	

FAMILY HISTORY: For your family members below, follow the line across the page and mark an X in those boxes which indicate their present state of health (good), (poor), or their death (write in the cause), and any of the illnesses that they have ever had. Print the names of your relatives living or dead in the spaces below.

	Health: Good	Poor	Deceased	Age at Death	Cause of Death	Alcohol/Drug Addiction	Allergy	Anemia	Arthritis	Cancer	Depression/Suicide Attempt	Diabetes	Gout	Heart Attack/Disease	High Blood Pressure	Kidney Stone	Mental Illness	Migraine Headaches	Sickle Cell Trait	Stroke	Tuberculosis	
Father:																						
Mother:																						
Brothers or Sisters:																						
Grandparents: (Mark an X for illnesses only)																						