MAINE MARITIME ACADEMY
Student Health Services
Castine, ME 04420

PERSONAL INFORMATION SHEET

Name: ____ Date of Birth_________________________

Street: ____ ☐ Male ☐ Female

City/ST/Zip: _______________________________________ Phone: ______________________________

E-mail:____ Cell phone: __________________________

EMERGENCY CONTACT INFORMATION:

Emergency Contact Person (#1) ____

Relationship: ____

Address____

(Street) (City) (State) (Zip)

Emergency numbers: Daytime: ____

Evening: ____

Cell: ____

E-Mail:____

Emergency Contact Person (#2):____

Relationship: ____

Address: ____

(Street) (City) (State) (Zip)

Emergency numbers: Daytime: ____

Evening: ____

Cell Phone: ____

E-Mail:____

COMPLETE THIS PAGE AND RETURN TO STUDENT HEALTH SERVICES AT MAINE MARITIME ACADEMY

MAINE MARITIME ACADEMY Name: ____________________________Date of birth _________

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MEDICAL HISTORY QUESTIONNAIRE

Family History

Relation	Sex	Age	State of Health	Occupation	If deceased, give age and cause of death
Mother					
Father					
Siblings:					

******COMMENT ON ALL "YES" ANSWERS IN PROVIDED OR ON A SEPARATE SHEET.**

Do you have or have you ever had:

Yes	No		Yes	No	
		Heart Murmur			Tumor, Growth, Cyst, Cancer
		Congenital Abnormalities			Hernia
		Rheumatic fever			Hemorrhoids
		Diabetes			Frequent or painful urination
		Frequent or severe headaches			Kidney Stone
		Dizziness or Fainting Spells			Blood/Sugar/Albumin in Urine
		Epilepsy/Seizures			Skin Infections/Acne
		Ear, Nose or Throat Problems			Arthritis
		Chronic cough			Bone or Joint Deformity/Pain
		Sinusitis			Back Pain
		Problems with teeth or gums			Pilonidal Sinus
		Frequent Sore Throats			Loss of Any Body Part
		Asthma			Painful or Trick Shoulder/Knee/Elbow
		Tuberculosis			Motion Sickness
		Shortness of breath			Insomnia
		Heart Palpitations			Depression
		High or Low Blood Pressure			Anxiety
		Recent Weight Gain or Loss			Substance Abuse (alcohol/drugs
		Recurrent Diarrhea			Attempted suicide
		Indigestion/Ulcer/Vomiting			Sleep Disorders
		Gall Bladder/Liver Disease			ADD/ADHD
		Jaundice			Irregular/Painful Menses
		Reaction to any Drugs/Medications			Surgery:
		Bee stings			
		Foods			
		Other			
		Do you wear: ____Glasses ____Contact lenses ____Hearing aids			
		Any Hospital Admissions? _____Yes _____No			
		Do you have any identifying marks-birth marks, scars, tattoos?			
		Have you bled excessively after injury or tooth extraction?			
		Are you currently on any medications?			
		Has your physical activity been restricted during the past five years?			
		Have you ever been on any long-term medications?			
		Have you ever received treatment or counseling for nervous or emotional conditions?			
		Have you ever attempted suicide?			
		Have you consulted or been treated by a physician in the past 2 years other than for a routine physical examination?			
		Have you been a patient in a psychiatric or rehabilitation hospital?			
		Have you had any illness or injury other than previously noted (including broken bones)?			

EXPLAIN ALL "YES" RESPONSES:

COMMENTS ON "YES" RESPONSES BY HEALTH CARE PROVIDER: