



MEDICAL HISTORY



PART A. PERSONAL INFORMATION (TO BE COMPLETED BY THE STUDENT)

- New Enrollment – Student from High School
- Readmission
- Transfer – Student from another university
- Special Permit
- Professional Development
- Graduate Student
- International Student
- Transfer within UPR System

Name: _____		Student Number: _____		Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer	
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		*Emancipated: <input type="checkbox"/> YES <input type="checkbox"/> NO			
Date of birth: _____ (day/month/year)		Age: _____		Place of birth: _____ (city/nation)	
Physical Address: _____			Mailing Address: _____		
Phone: _____			Institutional Email: _____		
Father's name: _____			Mother's name: _____		
Father's phone: _____			Mother's phone: _____		
In case of emergency notify: _____		Relationship: _____		Phone: _____	
In case of emergency notify: _____		Relationship: _____		Phone: _____	

PART B. HEALTH CONDITIONS (TO BE COMPLETED BY YOU)

Check those diseases or conditions you have or have had:

<input type="checkbox"/> Emotional Disorders	<input type="checkbox"/> Respiratory Diseases	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Sexually Transmitted Diseases	<input type="checkbox"/> Otitis Media
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Mumps
<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Poliomyelitis
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Speech Defect	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Chronic Intestinal Problems
<input type="checkbox"/> Hearing Defect	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Orthopedic Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Severe Trauma
<input type="checkbox"/> Skin Diseases	<input type="checkbox"/> Frequent Throat Infections	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Psychiatric Illness	<input type="checkbox"/> Malignancy	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Chickenpox

Please answer the following questions:
If affirmative, provide details; if negative, please write No or None

Other health problems:
Current treatment, if any:
Surgeries or procedures (operations):
Allergies to medications or food:
Hospitalizations or Illnesses in the last year:

*Forms for emancipated minor patients or with Tutor signature must be accompanied by accrediting evidence of emancipation or Tutor assignment.

Student's Signature

Tutor or Guardian Signature (for those under 21)

Date (day/month/year)