HEBREW UNION COLLEGE – JEWISH INSTITUTE OF RELIGION
היברו יוניון קולג - מכון למדעי היהדות

MEDICAL FORM – Part 1

STUDENT'S MEDICAL HISTORY

(To be completed by the *Student*)

INSTRUCTIONS: Please complete your medical history and return this form by mail or scanned email by to:

Hebrew Union College-Jewish Institute of Religion
National Office of Recruitment and Admissions
3101 Clifton Avenue
Cincinnati, OH 45220-2488
admissions@huc.edu

STUDENT'S NAME _____
(Print) Last First Middle

ADDRESS _____
Street City State Zip Code

PHONE _____ DATE OF BIRTH _____ COUNTRY OF BIRTH _____

IN CASE OF EMERGENCY, CONTACT _____ RELATIONSHIP _____

ADDRESS _____
Street City State Zip Code

PHONE (business)_____ PHONE (residence) _____ PHONE (cell)_____

STUDENT'S SIGNATURE: _____ Date: _____

FAMILY HISTORY

CHECK EACH ITEM	*YES*	*NO*	*RELATIONSHIP*	*CHECK EACH ITEM*	*YES*	*NO*	*RELATIONSHIP*
TUBERCULOSIS (If Yes, Give Details Below, Year Exposed & X-Ray)				STROKE			
DIABETES				ASTHMA, HAY FEVER, HIVES			
HIGH BLOOD PRESSURE				EPILEPSY OR CONVULSIONS			
HEART TROUBLE				NERVOUS OR MENTAL DISEASE			
MOTHER LIVING?				DRUG OR ALCOHOL ADDICTION			
FATHER LIVING?				CANCER			
NO. OF BROTHERS LIVING? __NO. OF SISTERS LIVING?			IF DECEASED, GIVE RELATIONSHIP AND CAUSE OF DEATH				

HAVE YOU EVER HAD OR HAVE YOU NOW ANY OF THE FOLLOWING: (IN LINES OF MULTIPLE STATEMENTS, CROSS OUT THE INAPPLICABLE WORDS.) EXPLAIN ALL POSITIVE ANSWERS BELOW.

CHECK EACH ITEM:	*YES*	*NO*		*YES*	*NO*		*YES*	*NO*		*YES*	*NO*
HEART TROUBLE			WEAR GLASSES			TUBERCULOSIS			SWOLLEN OR PAINFUL JOINTS		
HIGH OR LOW BLOOD PRESSURE			NOSE OR THROAT TROUBLE			STOMACH OR INTESTINAL TROUBLE			LAMENESS, PARALYSIS, POLIO		
RHEUMATIC FEVER			EAR TROUBLE (OTITIS)			JAUNDICE OR LIVER DISEASE			MOTION SICKNESS (TRAIN, CAR, ETC)		
SCARLET FEVER			SINUSITIS			APPENDICITIS			DIZZY OR FAINTING SPELLS		
DIPHTHERIA			CHRONIC OR FREQUENT COLDS			HERNIA			EPILEPSY		
MUMPS			HAY FEVER, ALLERGY			SKIN DISEASES, BOILS			CONVULSIONS		
WHOOPING COUGH			ASTHMA			PAINFUL OR TRICK SHOULDER			NERVOUS TROUBLE (ANY KIND)		
MEASLES			REACTION TO SERUM OR DRUGS			TRICK OR LOCKED KNEE			SUGAR OR ALBUMIN IN URINE		
CHICKENPOX			CHRONIC COUGH			LOSS OF ARM, LEG, FINGER, OR TOE			KIDNEY TROUBLE		
MONONUCLEOSIS			SHORTNESS OF BREATH			BONE OR JOINT DEFORMITY			DIABETES		
CANCER			PSYCHOLOGICAL DISORDER			ADDICTION			OTHER		

IF YES, OR ANY OTHER DISEASE OR CONDITIONS, GIVE DETAILS: _____

_____

_____

HAS YOUR HEALTH BEEN _____GOOD _____ FAIR _____POOR IF NOT GOOD, EXPLAIN _____

_____

_____

_____

CHECK EACH ITEM:	YES	*NO*	*IF YES, EXPLAIN BELOW, PLEASE NUMBER ANSWERS.*
1. HAVE YOU EVER BEEN REFUSED EMPLOYMENT OR EVER BEEN UNABLE TO HOLD A JOB BECAUSE OF YOUR HEALTH?			
2. HAVE YOU BEEN UNABLE TO TAKE PHYSICAL EDUCATION OR PARTICIPATE IN SPORTS BECAUSE OF YOUR HEALTH?			
3. HAVE YOU BEEN DENIED LIFE INSURANCE OR REJECTED FOR MILITARY SERVICE BECAUSE OF YOUR HEALTH?			
4. HAVE YOU CONSULTED OR BEEN TREATED BY A CLINIC OR PHYSICIAN IN THE PAST 5 YEARS FOR REASONS OTHER THAN ROUTINE CHECKUPS?			
5. HAVE YOU EVER HAD ANY SERIOUS ILLNESS, INJURY, OR OPERATION NOT LISTED ABOVE?			
6. ARE YOU TAKING ANY MEDICATION REGULARLY?			
7. HAVE YOU EVER BEEN HOSPITALIZED FOR MENTAL OR EMOTIONAL			

CHECK EACH ITEM:	YES	*NO*	*IF YES, EXPLAIN BELOW, PLEASE NUMBER ANSWERS.*
ILLNESS? WHEN? WHERE?			
8. HAVE YOU EVER HAD TO DISCONTINUE STUDY OR WORK FOR ANY PERIOD OWING TO PHYSICAL ILLNESS, NERVOUS DISTURBANCES?			
9. HAVE YOU EVER PARTICIPATED IN A DRUG OR ALCOHOL RECOVERY PROGRAM?			

Student's Last Name: