Bachelor of Ministry Degree Program
Student Health Record

Name _____
(LAST) (FIRST) (MIDDLE)

FAMILY HISTORY

Relation	Age	If deceased, state cause of death
Father	____	_____
Mother	____	_____
Brother(s)	_____	_____
	_____	_____
	_____	_____
Sister(s)	_____	_____
	_____	_____
	_____	_____
Spouse	_____	_____
Children	_____	_____
	_____	_____
	_____	_____

Has any member of your immediate family had any of the following?

Yes	No	(Check each item)	Relation(s)
☐	☐	Tuberculosis	_____
☐	☐	Diabetes	_____
☐	☐	Cancer	_____
☐	☐	Mental illness	_____
☐	☐	Nervous breakdown	_____
☐	☐	Heart trouble	_____
☐	☐	Stomach trouble	_____
☐	☐	Allergy – Asthma	_____
☐	☐	Epilepsy (seizures)	_____
☐	☐	Depression	_____
☐	☐	Suicidal tendencies	

PAST ILLNESSES: If you have had any of the following, please check.

- ☐ Scarlet Fever
- ☐ Diptheria
- ☐ Chicken Pox
- ☐ Rheumatic Fever
- ☐ Frequent or severe Headaches
- ☐ Sinusitis or Hay Fever
- ☐ Diabetes
- ☐ Tuberculosis – Night Sweats
- ☐ Pneumonia
- ☐ Frequent colds or cough
- ☐ Frequent indigestion
- ☐ Stomach or intestinal difficulty
- ☐ Gall bladder or liver difficulty
- ☐ Appendicitis
- ☐ Any allergies
- ☐ Recent weight gain or loss
- ☐ Arthritis
- ☐ Bone, joint or other deformity
- ☐ Paralysis (including Polio)
- ☐ Epilepsy or seizures
- ☐ Frequent difficulty sleeping
- ☐ Excessive worry or depression

Are you allergic to any shots or medications? _____ If yes, explain: _____

_____

Is there any reason why you should not take physical education? _____ If yes, explain: _____

State pertinent facts about conditions checked above. List other diseases, operations, or injuries you have had. _____

_____

_____

Please detail here any medical condition that might hinder your academic performance. Use the back of the page if needed _____

_____

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