

# Medical History

Commonwealth Baptist College  
 Attn: Admissions Office  
 3440 Versailles Road, Lexington, KY 40510  
 Phone: 1-877-682-8318

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
 (City) (State) (Zip)

Marital Status: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: \_\_\_\_\_ Race: \_\_\_\_\_

Occupation: \_\_\_\_\_ Do you intend to live in the dormitories: \_\_\_\_\_

Do you intend to enroll part time? \_\_\_\_\_ full time? \_\_\_\_\_

Are you hearing/hearing impaired/deaf? \_\_\_\_\_

## Personal History

(If yes on any of the following, please explain)

| YES | NO |                     | YES | NO |                                     |
|-----|----|---------------------|-----|----|-------------------------------------|
|     |    | Drug Abuse          |     |    | Chicken Pox                         |
|     |    | Diabetes            |     |    | Venereal Disease                    |
|     |    | Seizures            |     |    | Liver Disease                       |
|     |    | Rheumatic Fever     |     |    | Stomach Ulcer/Gastritis             |
|     |    | Arthritis           |     |    | Gall Bladder Disease                |
|     |    | Skin Problems       |     |    | Allergies                           |
|     |    | High Blood Pressure |     |    | Pneumonia                           |
|     |    | Heart Disease       |     |    | Asthma                              |
|     |    | Tuberculosis        |     |    | Kidney Disease                      |
|     |    | Thyroid Disease     |     |    | Previous Pregnancies                |
|     |    | Anemia              |     |    | Migraine Headaches                  |
|     |    | Scoliosis           |     |    | Mumps / Measles                     |
|     |    | Back Injury         |     |    | STD's (ie: condyloma, HIV positive) |

List all medications taken regularly: \_\_\_\_\_

Surgical History: \_\_\_\_\_

History of Injuries: \_\_\_\_\_

Have you ever psychological or psychiatric counsel? YES NO

Name of Doctor: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Name of Facility: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Dates of Care: \_\_\_\_\_

(Please attach a separate letter indicating the circumstances and any medications given)

## FAMILY HISTORY

(Give state of health or cause of death.)

Brother(s) \_\_\_\_\_  
Sister(s) \_\_\_\_\_  
Father \_\_\_\_\_  
Paternal Grandparents \_\_\_\_\_ Mother \_\_\_\_\_  
Maternal Grandparents \_\_\_\_\_

## IMMUNIZATIONS

(Give month, day, and year)

DPT (Diphtheria, Tetanus, Whooping Cough) \_\_\_\_\_  
Measles (Rubeola) \_\_\_\_\_  
German Measles (Rubella) \_\_\_\_\_  
OPV (Oral Polio) \_\_\_\_\_ Mumps \_\_\_\_\_

## TO BE COMPLETED BY YOUR PHYSICIAN

-- not more than one year prior to enrollment.

(This portion NOT required for part-time, off-campus students)

Date of physical \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Temperature \_\_\_\_\_  
Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
VISION: Without glasses R \_\_\_\_\_ L \_\_\_\_\_  
With glasses/contacts R \_\_\_\_\_ L \_\_\_\_\_  
URINE: Sugar \_\_\_\_\_ Ketones \_\_\_\_\_  
T.B. TINE: Date given \_\_\_\_\_ Date read \_\_\_\_\_ Results \_\_\_\_\_  
(\* If positive, chest X-ray date) Date read \_\_\_\_\_ Results \_\_\_\_\_  
GENERAL APPEARANCE: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_  
SKIN \_\_\_\_\_ Recurring skin problems \_\_\_\_\_  
EARS \_\_\_\_\_  
NOSE/THROAT \_\_\_\_\_  
HEART \_\_\_\_\_  
LUNGS \_\_\_\_\_  
Asthma? Yes/No Frequency of attacks \_\_\_\_\_ (daily-monthly)  
Medication \_\_\_\_\_  
ABDOMEN \_\_\_\_\_ Any hernias \_\_\_\_\_  
GYNECOLOGICAL HISTORY \_\_\_\_\_  
EXTREMITIES \_\_\_\_\_  
Orthopedic defects \_\_\_\_\_  
General comments \_\_\_\_\_  
Does this person seem to be capable of being enrolled in college? Yes / No

**Physician's Signature**

\_\_\_\_\_  
**Physician's Name (Please Print)**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**Telephone** \_\_\_\_\_