

Idaho State UNIVERSITY

Idaho State University Confidential Health History Questionnaire

Name: _____ Bengal ID: _____
 First Middle Last

ISU Study Abroad Program: _____

Program Start Date _____ Program End Date _____

Emergency Contact Information

Name: _____ Phone: (____) _____ - _____

Address: _____

Apt No. _____

City _____ State _____ Zip Code _____

Relationship to Participant: _____

Health History

Please list any recent or continuing physical or mental health problems:

Please indicate if you have had any of the following:

Yes ___ No ___ Anorexia/bulimia

Yes ___ No ___ High blood pressure

Yes ___ No ___ Asthma

Yes ___ No ___ Heart problem

Yes ___ No ___ Hay fever/allergies

Yes ___ No ___ Jaundice/hepatitis

Yes ___ No ___ Back problems

Yes ___ No ___ Protein/sugar in urine

Yes ___ No ___ Bladder/kidney problem

Yes ___ No ___ Ulcers/stomach problems

Yes ___ No ___ Depression

Yes ___ No ___ Epilepsy/convulsion

Yes ___ No ___ Surgery

Yes ___ No ___ Diabetes

If YES, please list the type and year of illness

Please explain how you are treating your "yes" responses

Drug Allergies Food/Other Allergies

___ Penicillin Dairy

___ Novocain/local anesthetic Wheat

___ Sulfa Bee stings

___ Other (specify)

Immunization History

Yes ___ No ___ Polio Immunization

Yes ___ No ___ Hepatitis

Yes ___ No ___ Measles, mumps rubella

Yes ___ No ___ Chickenpox

Yes ___ No ___ Tetanus booster

Yes ___ No ___ Rabies

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Immunizations (cont)

Yes ___ No ___ Yellow fever (required for Ghana)

I understand that I am responsible for obtaining the necessary immunizations for my program participation. _____ (Initial)

Medicines

Please list any medicines (pills or injections) you take regularly.

Tuberculosis

Have you ever lived in close contact with anyone who had tuberculosis? Yes ___ No ___
(if yes, when) _____

Previous skin test

Negative Year _____

Positive Year _____

Never tested

Family Medical History

Yes ___ No ___ High blood pressure Relation to you: _____

Yes ___ No ___ Asthma Relation to you: _____

Yes ___ No ___ Heart disease Relation to you: _____

Yes ___ No ___ Hay fever/allergies Relation to you: _____

Yes ___ No ___ Sickle cell Relation to you: _____

Other Medical Conditions Not Listed Above

Current Health Insurance Coverage

Insurance Provider & Policy # _____

I affirm that all of the above information is correct and to the best of my knowledge. I am aware of all personal medical needs, and I state that there are no health related reasons or problems, which preclude or restrict my participation. I have disclosed all medical, health, or learning conditions, which may require assistance or accommodation at the program site.

Printed Name

Date

Signature

Date