LAKE AREA TECHNICAL INSTITUTE
WATERTOWN, SD 57201

To Be Completed By Student

REPORT OF MEDICAL HISTORY

To Be Completed Before Going to Your Physician for Examination

This information is strictly for the use of the health services and will not be released to anyone without your knowledge and consent.

Name _____ Social Security No. _____ Sex: M ☐ F ☐
(Last) (First) (Middle)

Home Address _____ Date of birth: _____
(Number of Street) (City or Town) (State and Zip Code)

Program Entering _____ Home Telephone _____

Name, Relationship and Address of Next of Kin _____ Telephone _____

Next of Kin's Business Address _____ Business Telephone _____

Hospital Insurance Policy and Number _____ Citizenship _____

Marital Status: S ☐ M ☐ Other ☐ Are You a Veteran? Branch and Length of Service _____

FAMILY HISTORY

	Age	State of Health	Occupation	Age of Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Have any of your relatives ever had any of the following?

	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Arthritis			
Stomach Disease			
Asthma, Hay Fever			
Epilepsy, Convulsions			

PERSONAL HISTORY: PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers in space below or on attached sheet of paper.

HAVE YOU HAD:	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Scarlet Fever			Insomnia			Shortness of Breath			Recurrent Diarrhea		
Measles			Frequent Anxiety			Hay Fever, Asthma			Rupture, Hernia		
German Measles			Frequent Depression			Chronic Cough			Recent Gain or Loss of Weight		
Mumps			Worry or Nervousness			Pain/Pressure in Chest			Dizziness, Fainting		
Diabetes			Recurrent Headache			Palpitations (Heart)			Weakness, Paralysis		
Epilepsy			Recurrent Colds			High or Low Blood Pressure			Venereal Disease		
Sinusitis			Head Injury with Unconsciousness			Rheumatic Fever or Heart Murmur			Albumin/Sugar in Urine		
Eye Trouble			Tuberculosis			Disease or Injury of Joints			Frequent Urination		
Ear, Nose, or Throat Trouble			Allergy			"Trick" Knee, Shoulder, etc.			Gum or Tooth Trouble		
Surgery			Penicillin			Back Problems					
Appendectomy			Sulfonamides			Tumor, Cancer or Cyst			FEMALES ONLY		
Tonsillectomy			Serum			Jaundice			Irregular Periods		
Hernia Repair			Foods (which)			Stomach or Intestinal Trouble			Severe Cramps		
Other			Other			Gallbladder Trouble or Gallstones			Excessive Flow		

A. Has your physical activity been restricted during the past five years? (Give reasons and duration.)		
B. Have you had difficulty with school, studies, or teachers? (Give details)		
C. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? (Give details.)		
D. Have you had any illness or injury or been hospitalized other than already noted? (Give details.)		
E. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (Other than routine checkups?)		
F. Have you been rejected for or discharged from military service because of physical, emotional, or other reasons? (If so, give reason.)		
G. Do you have any questions in regard to your health, family history, or other matters, such as premarital counseling, which you would like to discuss now with a member of the staff of the health services?		

COMMENTS

(OVER)

To Be Completed By Doctor

LAKE AREA TECHNICAL INSTITUTE
WATERTOWN, SD 57201

REPORT OF HEALTH EVALUATION

This Form Must Be Completed Before the Student Will Be Allowed to Attend Class

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete the physician's form. Please comment on all positive answers. The information will be used only as a background for providing health care, if this is necessary. This information is strictly for the use of the Health Service and will not be released without student consent.

Name _____ Sex: M ☐ F☐
(Last) (First) (Middle)

BP _____/_____ Height _____ inches Overweight _____
Weight _____ pounds Underweight _____
Corrected Vision: Right 20/_____ Left 20/_____

Hemoglobin _____ gm/%

Urinalysis: Sugar _____ Albumin _____
Micro _____

Are there any abnormalities of the following systems? If yes, use the description column to describe.

	Yes	No	Description
1. Head, Ears, Nose or Throat			
2. Respiratory			
3. Cardiovascular			
4. Gastrointestinal			
5. Hernia			
6. Eyes			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			

Recommendations for physical activity:

Intramural: Unlimited _____ Limited _____ Explain _____

Is the patient now under treatment for any medical or emotional condition? Yes _____ No _____

Are there any conditions that may limit the student as a health care provider? Yes _____ No _____ If yes, please explain.

Health Care Provider's Signature _____
Address _____
Print Last Name _____
Date _____

Return all information to: Admissions Office
Lake Area Tech
Box 730
Watertown, SD 57201

(OVER)