

Student ID # _____

Semester beginning:			
___ Fall	___ Spring	___ Summer	20___

**NORTHERN MAINE COMMUNITY COLLEGE
HEALTH INVENTORY**

Name _____ Age ___ Sex ___ Height ___ Weight ___
Date of Birth _____ SS # _____ Phone _____
Address _____ City _____ State _____ Zip _____
Program of study _____
Insurance Provider _____ Certificate # _____
Subscriber's name _____ Group # _____
Relationship to subscriber _____

A. **Allergies** (to medicines, food, etc.) _____

B. **Disabilities** (optional; documentation required if requesting specific accommodations)
Physical _____
Mental _____
Learning _____

C. **Name all medications you take regularly;** include over the counter medication. _____

D. Do you currently **smoke** tobacco or have you smoked tobacco in the last month: yes/no _____

E. How many drinks containing **alcohol** do you have on a typical day _____

Sleep hrs per night _____ **Exercise** (per week) hours _____

F. **Illnesses:** Check any that apply to you
____ Diabetes ___ Heart Trouble ___ Ulcers ___ Cancer
____ High Blood Pressure ___ Tuberculosis ___ Kidney/ Bladder Trouble ___ Bowel Disease
____ Gland Disease (thyroid) ___ Serious Infections ___ Lung Disease (asthma, Bronchitis) ___ Nervous Condition
____ Ear or Eye Trouble ___ Other _____

G. **Injuries:** Serious Injuries _____ Operations _____
Hospitalizations within the past year _____

H. **Family History:** Please indicate which member of the family:
____ Diabetes ___ Heart Trouble
____ Cancer ___ Bowel Disease
____ Tuberculosis ___ Ear or Eye Trouble
____ Blood Disease ___ Lung Disease
____ Ulcers ___ Kidney Disease
____ Nervous Conditions ___ Psychiatric Illness
____ High Blood Pressure

I. **Health History:** Check any of the following that have been a problem for you (Review of Systems)

- | | | |
|--|--|---|
| 1. Respiratory
___ sneezing or gasping
___ coughing spells
___ daily cough
___ cough up phlegm
___ cough up blood
___ frequent chest cold
___ excessive sweating | 2. Cardiovascular
___ rapid heartbeat
___ chest pains
___ dizzy spells
___ shortness of breath
___ swollen feet/ankles
___ leg cramps
___ hot flashes
___ heart murmurs | 3. Digestive
___ pain in rectum
___ bloated stomach
___ stomach pains
___ vomited blood
___ difficulty swallowing
___ constipation
___ loose bowels
___ black stools/rectal bleeding
___ gray stools
___ heartburn |
|--|--|---|

4. Ears

- trouble hearing
- earaches
- discharge
- ringing in ears
- motion sickness

7. Skin

- cysts or lumps
- itching or burning
- acne
- easy bleeding
- easy bruising

10. Neurological

- fainting
- numbness or tingling
- convulsions or fits
- change in handwriting
- tremors or shaking
- stroke

13. General/Emotional

- weight change
- sleeping difficulties
- Increased fatigue
- increased/decreased appetite
- lack of exercise
- heavy coffee, tea, or soda drinker

5. Nose and Throat

- poor sense of smell
- congested nose
- running nose
- frequent head colds
- nose bleeds
- enlarged tonsils
- hoarse voice

8. Head and Neck

- frequent head aches
- neck pains
- neck lumps
- swelling

11. Musculoskeletal

- aching muscles/joints
- swollen joints
- weakness

6. Mouth

- bleeding gums
- dental problems
- swelling of gums/jaws
- sore tongue
- taste change

9. Eyes

- glasses
- blurred vision
- eyesight worse
- double vision
- see halos
- eye pain or itch
- watery eyes

12. Urinary

- frequent urination
- burning on urination
- brown, black, or bloody urine
- difficulty starting urine
- urgency

14. For Women Only

- painful periods
- lumps in breasts
- bleeding between periods\vaginal discharge
- Method of birth control _____

Please note any medical conditions that were not covered on this questionnaire. (Attach additional sheets, if necessary)

I authorize N.M.C.C Health Center to medically treat or refer _____ as deemed necessary. Student name

Signature _____ Date _____ Emergency Contact # _____
Parent/Guardian (if under 18 years old)

Signature _____ Date _____ Emergency Contact # _____
Student

Return to: Admissions
NMCC
33 Edgemont Drive
Presque Isle, ME 04769