TEXAS A&M INTERNATIONAL UNIVERSITY
COLLEGE OF NURSING AND HEALTH SCIENCES
DR. F.M. CANSECO SCHOOL OF NURSING

Medical History Form

1. Are you presently under a doctor's care or taking medication? _____ Yes _____ No
   If yes, please list name of physicians and/or medical facilities, diagnosis and duration.
   List name and dose of all medicines (prescribed and over the counter).

   _____

   _____

   _____

2. Have you consulted a physician in the past year? _____ Yes _____ No

   _____

   _____

   _____

3. Have you been advised by a physician to avoid or limit any activity?
   _____ Yes _____ No

   _____

   _____

4. Have you ever been the victim of an occupational injury, illness or disease?
   _____ Yes _____ No
   If yes, please describe:

   _____

   _____

   _____

5. Do you have any significant past illnesses and/or injuries not listed above?
   _____ Yes ____ No
   If yes, please describe:

   _____

   _____

   _____

These answers are complete and correct to the best of my knowledge and belief.

_____ _____

Print Name Signature Date