



REALITY COLLEGE

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Medical Information

NOTE: Information provided to Reality College is kept in strict confidence. It will not be sold or given to any outside entity at any time.

GENERAL INFORMATION

PLEASE TYPE OR PRINT

CLASSIFICATION (check one)

- New Freshman
- Transfer (Request previous transcripts)
- Re-Activation
- Dates of last attendance _____
- Special Student (non-diploma)

ENROLLMENT DATE (complete and check all that apply)

- Fall, 20____ (i.e. 2004)
- Winter, 20____ (i.e. 2004)
- Spring, 20____ (i.e. 2004)
- Other _____ (i.e. 2004)

HOUSING (check one)

- On Campus
- Off Campus

HEALTH HISTORY

PERSONAL INFORMATION:

Name _____ Social Security No. _____
Last First M.I. Maiden

Address _____ Gender: _____
Street Apt.

City State Zip Marital Status: _____

Daytime Phone (____) _____ Evening Phone: (____) _____ Date of Birth: _____

Name of Parent or Guardian _____

Address of Parent or Guardian _____
Street Apt.

City State Zip Phone (____) _____

FAMILY MEDICAL HISTORY: Have any of your relatives had any of the following diseases/disorders? If yes, please explain relationship to you.

| | Yes | No | Relationship | | Yes | No | Relationship |
|--------------|--------------------------|--------------------------|--------------|--------------------|--------------------------|--------------------------|--------------|
| Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Mental Illness | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Migraine Headaches | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | |

PERSONAL HISTORY: Have you ever experienced any of the following? If yes, give approximate age.

| | Yes | No | Age | | Yes | No | Age |
|----------------|--------------------------|--------------------------|-------|---------------------------|--------------------------|--------------------------|-------|
| Mumps | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Whooping Cough | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Emotional Illness | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Malaria | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Mononucleosis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Measles | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Use of Tobacco | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Use of Drugs | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Use of Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Impaired Sight | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Reg. Use of Tranquilizers | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Reg. Use of Diet Pills | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diphtheria | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Scarlet Fever | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Typhoid Fever | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Appendicitis | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Hepatitis B | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Tonsillitis | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Chicken Pox | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Draining Ears | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Please list any other illness(es) or severe injuries: _____

List any surgeries you have undergone in the past five (5) years: _____