



Health History Form

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Name: _____

Do you have, or have you had, any of the following:

Tuberculosis _____ Heart Trouble _____

Diabetes _____ Epilepsy _____

Paralysis _____ Fainting Spells _____

1. Do you have any other physical problems of which we should be aware? _____

2. Do you have any communicable disease? _____

If yes, explain: _____

3. Are you receiving treatment or has treatment been recommended because of health? _____

Physical condition: _____

Any continuing health problem? _____

4. Do you have any disability (such as vision, hearing, walking, etc.) that would affect class attendance and/or participation? _____

If yes, explain: _____

Signed: _____ Date: _____

Address: _____

City _____ State _____ Zip _____