Medical History

HEALTH CENTER INFORMATION
(REQUIRED TO BE ON FILE IN HEALTH CENTER)

CONFIDENTIAL

Name: _____ Circle One: Unmarried Married Divorced

Soc. Sec. Number: _____ Date of Birth: _____ Age: _____ Sex: M F

Permanent Address: _____ Cell Phone: ( ) _____
STREET CITY STATE ZIP

IN AN EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Address: _____
STREET CITY STATE ZIP

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Personal Health History

A. Acute Infectious Disease	Yes	No
Chicken Pox	○	○
Hepatitis	○	○
Infectious Mononucleosis	○	○
Typhoid Fever	○	○
Sexually Transmitted Infections	○	○
HIV Infected	○	○
MSRA infection	○	○

B. Diseases or health concerns	Yes	No
Rheumatic Fever	○	○
Recurrent painful or draining ear(s)	○	○
Recurrent tonsillitis or strep throat	○	○
Pneumonia/bronchitis	○	○
Kidney/bladder infections or disease	○	○
Diabetes	○	○
High blood pressure	○	○

B. Diseases or health concerns	Yes	No
Arthritis	○	○
Convulsions/seizures disorder	○	○
Dental problems	○	○
Colitis or colon problems	○	○
Gastric or Duodenal Ulcer	○	○
Asthma	○	○
Hay fever	○	○
Congenital heart problems	○	○
Heart disease	○	○
Diminished hearing	○	○
Severe visual problems	○	○
Contact lens/glasses	○	○
Gall bladder or liver disease	○	○
Anemia	○	○
Abnormal bleeding tendency	○	○

B. Diseases or health concerns	Yes	No
Cancer	○	○
Frequent urination	○	○
Drug or alcohol dependency	○	○
Hernia	○	○
Dizziness or fainting	○	○
Excessive worry, depression, anxiety	○	○
Severe headaches/migraines	○	○
Chronic skin problems	○	○
Low blood sugar	○	○
Orthopedic problem (knee, back, etc.)	○	○
Tuberculosis	○	○
Sinus infections	○	○
Sickle Cell Trait	○	○
Anorexia/bulimia	○	○
Other	○	○

Have you ever had?	Yes	No	Kind	Type
Surgery	○	○	_____	_____
Serious injury (head, broken bone, etc.)	○	○	_____	
Psychiatric or psychological counseling	○	○	_____	_____
Allergic reaction to:				
Medication	○	○	_____	_____
Food	○	○	_____	_____
Stinging insects	○	○	_____	_____
Pollen	○	○	_____	_____
Physical disability	○	○	_____	_____
Learning disability	○	○	_____	_____

While at Concordia will you:	Yes	No
Need allergy shots	○	○
Need a special diet	○	○
Need consultations with a physician	○	○
Be taking prescription medicine or injections	○	○
Require restricted physical activity	○	○

Use this section to comment on all positive answers and to describe any serious medical or mental conditions, medications and medical recommendations. If you have a potentially serious medial condition, we recommend you provide a medical history summary from your physician (diagnosis, recommended treatment and follow-up, and any other pertinent information).

_____

_____

_____

_____

_____

Date of last physical examination: _____ Print name and address of health care provider: _____

FAMILY HISTORY

	Age	State of health (excellent, good, fair, poor)	Occupation	Age at death	Cause of death
Father:					
Mother:					
Siblings:					

Have your father, mother, brother, sister or grandparent ever been diagnosed as having any of the following conditions:

	Yes	No	Relationship		Yes	No	Relationship
Asthma	○	○		Alcoholism	○	○	
Cancer	○	○		Abnormal bleeding tendency	○	○	
Diabetes	○	○		High blood pressure	○	○	
Epilepsy	○	○		Migraine or severe headaches	○	○	
Heart disease	○	○		Celiac disease	○	○	

To the best of my knowledge, the above information is accurate. I understand the information I provided will be used to assist medical personnel in case of emergency.

Signature of student: _____ **Date:** _____

Please enclose this form in the postage paid envelope.
Concordia University, Attn: Health Center, 800 N. Columbia Avenue, Seward, NE 68434