

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: _____ Phone: () _____
STREET CITY STATE ZIP

In an emergency, contact: Name: _____ Relationship: _____

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

Personal Health History

A. Acute Infectious Disease	Yes	No	B. Diseases or health concerns	Yes	No	C. Menstrual history (females only)	Yes	No
Chicken Pox	<input type="radio"/>	<input type="radio"/>	Heart disease	<input type="radio"/>	<input type="radio"/>	Age of onset _____		
Hepatitis	<input type="radio"/>	<input type="radio"/>	Diminished hearing	<input type="radio"/>	<input type="radio"/>	Problems _____		
Infectious Mononucleosis	<input type="radio"/>	<input type="radio"/>	Severe visual problems	<input type="radio"/>	<input type="radio"/>	(cramps, irregular cycle, excessive flow)	<input type="radio"/>	<input type="radio"/>
Typhoid Fever	<input type="radio"/>	<input type="radio"/>	Contact lens/ glasses	<input type="radio"/>	<input type="radio"/>	Oral contraceptives	<input type="radio"/>	<input type="radio"/>
Sexually Transmitted Infections	<input type="radio"/>	<input type="radio"/>	Gall bladder or liver disease	<input type="radio"/>	<input type="radio"/>	Female infections	<input type="radio"/>	<input type="radio"/>
HIV Infected	<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>	Pregnancies	<input type="radio"/>	<input type="radio"/>
			Abnormal bleeding tendency	<input type="radio"/>	<input type="radio"/>	Termination of pregnancy	<input type="radio"/>	<input type="radio"/>
			Cancer	<input type="radio"/>	<input type="radio"/>			
B. Diseases or health concerns	Yes	No	Frequent urination	<input type="radio"/>	<input type="radio"/>			
Rheumatic Fever	<input type="radio"/>	<input type="radio"/>	Drug or alcohol dependency	<input type="radio"/>	<input type="radio"/>			
Recurrent painful or draining ear(s)	<input type="radio"/>	<input type="radio"/>	Hernia	<input type="radio"/>	<input type="radio"/>			
Recurrent tonsillitis or strep throat	<input type="radio"/>	<input type="radio"/>	Dizziness or fainting	<input type="radio"/>	<input type="radio"/>			
Pneumonia/ bronchitis	<input type="radio"/>	<input type="radio"/>	Excessive worry, depression, anxiety	<input type="radio"/>	<input type="radio"/>			
Kidney/ bladder infections or disease	<input type="radio"/>	<input type="radio"/>	Severe headaches/ migraines	<input type="radio"/>	<input type="radio"/>			
Diabetes	<input type="radio"/>	<input type="radio"/>	Chronic skin problems	<input type="radio"/>	<input type="radio"/>			
High blood pressure	<input type="radio"/>	<input type="radio"/>	Low blood sugar	<input type="radio"/>	<input type="radio"/>			
Arthritis	<input type="radio"/>	<input type="radio"/>	Orthopedic problem (knee, back, etc.)	<input type="radio"/>	<input type="radio"/>			
Convulsions/ seizures disorder	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>			
Dental problems	<input type="radio"/>	<input type="radio"/>	Sinus infections	<input type="radio"/>	<input type="radio"/>			
Colitis or colon problems	<input type="radio"/>	<input type="radio"/>	Sickle Cell Trait	<input type="radio"/>	<input type="radio"/>			
Gastric or Duodenal Ulcer	<input type="radio"/>	<input type="radio"/>	Anorexia/ bulimia	<input type="radio"/>	<input type="radio"/>			
Asthma	<input type="radio"/>	<input type="radio"/>	Other	<input type="radio"/>	<input type="radio"/>			
Hayfever	<input type="radio"/>	<input type="radio"/>						
Congenital heart problems	<input type="radio"/>	<input type="radio"/>						

Comment on all positive answers: (A,B,C)

Have you ever had?	Yes	No	Kind	Type	While at Concordia will you:	Yes	No
Surgery	<input type="radio"/>	<input type="radio"/>	_____	_____	Need allergy shots	<input type="radio"/>	<input type="radio"/>
Serious injury (head, broken bone ect.)	<input type="radio"/>	<input type="radio"/>	_____	_____	Need a special diet	<input type="radio"/>	<input type="radio"/>
Psychiatric or psychological counseling	<input type="radio"/>	<input type="radio"/>	_____	_____	Need consultations with a physician	<input type="radio"/>	<input type="radio"/>
Allergic reaction to:					Be taking prescription medicine or injections	<input type="radio"/>	<input type="radio"/>
Medication	<input type="radio"/>	<input type="radio"/>	_____	_____	Require restricted physical activity	<input type="radio"/>	<input type="radio"/>
Food	<input type="radio"/>	<input type="radio"/>	_____	_____			
Stinging insects	<input type="radio"/>	<input type="radio"/>	_____	_____			
Pollen	<input type="radio"/>	<input type="radio"/>	_____	_____			
Physical disability	<input type="radio"/>	<input type="radio"/>	_____	_____			
Learning disability	<input type="radio"/>	<input type="radio"/>	_____	_____			

Please, if you have a potentially serious medical condition:

Use this section to describe any serious medical or mental conditions, medications and medical recommendations.
 Make an appointment to discuss the medical condition with the campus nurse, 800 535 5494, ext. 7224.
 Tell those close to you what to do in the event of an emergency (roommate, instructor, resident counselor or resident assistant).
 Wear Medic-Alert identification.
 Provide a medical history summary from your physician (diagnosis, recommended treatment and follow-up, and any other pertinent information.)

Physical Examination: All students participating in athletics are required to submit a physical examination to the athletic office before beginning practice. Athletic physical forms are available online. A physical examination, including cholesterol level for all students is recommended.

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	<input type="radio"/>	<input type="radio"/>	_____	Alcoholism	<input type="radio"/>	<input type="radio"/>	_____
Cancer	<input type="radio"/>	<input type="radio"/>	_____	Abnormal bleeding tendency	<input type="radio"/>	<input type="radio"/>	_____
Diabetes	<input type="radio"/>	<input type="radio"/>	_____	High blood pressure	<input type="radio"/>	<input type="radio"/>	_____
Epilepsy	<input type="radio"/>	<input type="radio"/>	_____	Migraine or severe headaches	<input type="radio"/>	<input type="radio"/>	_____
Heart disease	<input type="radio"/>	<input type="radio"/>	_____	Celiac disease	<input type="radio"/>	<input type="radio"/>	_____

Immunization Requirements for Registration

(May be filled in by a health care provider. Vaccination records can be obtained from family, high school or physician records. Transcribe information or include a copy of documentation with your name.)

In order to complete your enrollment at Concordia University, all new and transfer students must provide proof of immunity to Measles and Mumps. (Two MMR vaccinations must be documented.) **DO NOT SEND ORIGINAL IMMUNIZATION RECORDS. Students who fail to provide the required proof of immunization during the first semester of admission will not be allowed to register for any following semesters until they are in compliance.**

Immunization History

First MMR (combined or divided)

Administered on 1st birthday or later.

(Immunization prior to 1st birthday not acceptable.)

MMR combined: _____

OR divided doses

Measles (Rubeola): _____

Mumps: _____

Rubella: _____

OR

Rubeola titer results: _____ Date: _____

Mumps titer results: _____ Date: _____

Rubella titer results: _____ Date: _____

Please list the date of completion for your primary series of:

Diphtheria-tetanus-pertussis: _____

Polio: _____

Second MMR (combined or divided)

Administered 30 days or more after the first.

MMR combined: _____

OR divided doses

Measles (Rubeola): _____

Mumps: _____

Rubella: _____

Please list the dates of your most recent immunization.

Tetanus: Td _____ Tdap _____

TB skin test: _____ Results: positive negative

Hepatitis B: 1 _____ 2 _____ 3 _____

Meningitis: _____

Varicella (Chicken Pox): _____

Request for Waiver of Immunizations

Medical exemption: The physical condition of the above named student is such that the required immunizations would endanger life or health.

Exemption for which immunizations: _____

Reason for exemption: _____

Check one: Permanent Temporary (date to be released): _____

Signature of physician: _____ Date: _____

Religious exemption: I request exemption based on religious beliefs, understanding that in the event of an outbreak I will be barred from campus for the duration of the outbreak which could last several weeks.

Signature: _____ Date: _____

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:** _____

I authorize Concordia University Health Center and/ or any Memorial Health Care System facility to treat any health problems for which I seek treatment and release medical information necessary to process insurance claims for benefits.

(*If student is under 19 years of age, both student and parent must sign.)

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

***Signature of parent/guardian:** _____ **Date:** _____

Please enclose the form the envelope marked **Confidential** to Concordia University Health Center, 800 N. Columbia Avenue, Seward, NE 68434.