Medical History

(Required to be on file in Health Center)

CONFIDENTIAL

Name ______________________________ **Soc. Sec. Number** ______________
First M. Last

Address ____
Street City State ZIP

Date of Birth ______________ **Age** ________ **Mobile Phone** ______________

○ Male ○ Female ○ Unmarried ○ Married ○ Divorced

Date of Last Physical Examination ______________

Name and Address of Health Care Provider ______________________________

IN AN EMERGENCY, CONTACT:

Name ______________________________ **Relationship** ______________

Address ____
Street City State ZIP

Home Phone ______________ **Work Phone** ______________ **Cell Phone** ______________

Personal Health History

Acute Infectious Disease

Yes No
- ○ ○ Chicken Pox
- ○ ○ Hepatitis
- ○ ○ Infectious Mononucleosis
- ○ ○ Typhoid Fever
- ○ ○ Sexually Transmitted Infections
- ○ ○ HIV Infected
- ○ ○ MSRA infection

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

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
- ○ ○ Cancer

Diseases or Health Concerns

Yes No
- ○ ○ Frequent urination
- ○ ○ Drug or alcohol dependency
- ○ ○ Hernia
- ○ ○ Dizziness or fainting
- ○ ○ Depression, anxiety
- ○ ○ Severe headaches/migraines
- ○ ○ Chronic skin problems
- ○ ○ Low blood sugar
- ○ ○ Orthopedic problem
- ○ ○ Tuberculosis
- ○ ○ Sinus infections
- ○ ○ Sickle Cell Trait
- ○ ○ Disordered eating
  Type: ______________
- ○ ○ Other

While at Concordia will you:

Yes No
- ○ ○ Need allergy shots
- ○ ○ Need a special diet
- ○ ○ Need consultations with a physician
- ○ ○ Require restricted physical activity
- ○ ○ Be taking prescription medicine or injections

Have you ever had?

Yes No — Type
- ○ ○ Surgery ______________
- ○ ○ Serious injury (head, broken bone, etc.) ______________
- ○ ○ Psychiatric or psychological counseling ______________
- ○ ○ Physical disability ______________
- ○ ○ Learning disability ______________

Allergic reaction to:
- ○ ○ Medication ______________
- ○ ○ Food ______________
- ○ ○ Stinging insects ______________
- ○ ○ Pollen ______________

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).

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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	Condition	Relationship
◯	◯	Asthma	
◯	◯	Cancer	
◯	◯	Diabetes	
◯	◯	Epilepsy	
◯	◯	Heart disease	
◯	◯	Alcoholism	
◯	◯	Abnormal bleeding tendency	
◯	◯	High blood pressure	
◯	◯	Migraine or severe headaches	
◯	◯	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.

STUDENT SIGNATURE ____________________ **DATE** ____________________

PLEASE ENCLOSE THIS FORM IN THE POSTAGE PAID ENVELOPE.