University Health Center
Report of Health History

Cairn UNIVERSITY | *Walk a Different Path*

This health form is to be completed in its entirety by all full-time students (12 credits or more) and part-time students (11 credits or less) of Cairn University. Please be sure to type or print clearly. The information you provide is confidential and strictly for the use of Student Health Services. It will not be released to anyone without your approval and is not related to the admissions process.

Personal Information:

Name: _____ (LAST) _____ (FIRST) _____ (MIDDLE INITIAL)

Social Security #: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Other: _____

Street: _____ City: _____ State: _____ Zip Code: _____

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

In case of emergency please notify:

Name: _____ Relationship: _____

Street: _____ (LAST) City: _____ (FIRST) State: _____ Zip Code: _____

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

Insurance Company Information:

Street: _____ City: _____ State: _____ Zip Code: _____

Business Phone: ( ) _____

Your Health Insurance Company: _____

Policy Number: _____ Contract Number: _____

PERSONAL HISTORY – Please **answer all questions**, using page 2 to comment on all positive answers. Check "current" if condition currently exists.
Have you ever had:

	YES	NO	CURRENT
Acne	☐	☐	☐
Anemia	☐	☐	☐
Asthma	☐	☐	☐
Back Problems	☐	☐	☐
Bladder Infections	☐	☐	☐
Bleeding Disorder	☐	☐	☐
Bronchitis	☐	☐	☐
Cardiac Problems	☐	☐	☐
Chest Pain	☐	☐	☐
Chicken Pox	☐	☐	☐
Chronic Cough	☐	☐	☐
Chronic Fatigue	☐	☐	☐
Colitis	☐	☐	☐
Cystic Fibrosis	☐	☐	☐
Diabetes	☐	☐	☐
Diseases/Injuries of Joints	☐	☐	☐
Dizziness/Faintness	☐	☐	☐
Ear Problems	☐	☐	☐
Eczema	☐	☐	☐
Eye Trouble	☐	☐	☐
Gallbladder Trouble	☐	☐	☐
Gum/Tooth Trouble	☐	☐	☐
Hay Fever	☐	☐	☐
Hearing Difficulty	☐	☐	☐
Head Injury	☐	☐	☐

	YES	NO	CURRENT
Hear Murmur	☐	☐	☐
Hepatitis			
Type: ☐ A ☐ B ☐ C			
Hernia	☐	☐	☐
Herpes (genital/oral)	☐	☐	☐
High Blood Pressure	☐	☐	☐
HIV Positive	☐	☐	☐
Hyperactivity	☐	☐	☐
Insomnia	☐	☐	☐
Intestinal Trouble	☐	☐	☐
Irritable Bowel	☐	☐	☐
Jaundice	☐	☐	☐
Kidney Infection	☐	☐	☐
Learning Disabilities	☐	☐	☐
Malaria	☐	☐	☐
Mononucleosis	☐	☐	☐
Neck Injury	☐	☐	☐
Nose/Throat Problems	☐	☐	☐
Palpitations (Heart)	☐	☐	☐
Pneumonia	☐	☐	☐
Recurrent Constipation	☐	☐	☐
Recurrent Diarrhea	☐	☐	☐
Recurrent Headache	☐	☐	☐
Recurrent Weight Gain	☐	☐	☐
Recurrent Weight Loss	☐	☐	☐

	YES	NO	CURRENT
Rheumatic Fever	☐	☐	☐
Schizophrenia	☐	☐	☐
Seizures	☐	☐	☐
Sexually Transmitted Disease	☐	☐	☐
Sinusitis	☐	☐	☐
Stomach Trouble	☐	☐	☐
Thyroid Problems	☐	☐	☐
Tuberculosis	☐	☐	☐
Tumor, Cancer, Cyst	☐	☐	☐
Weakness, Paralysis	☐	☐	☐
FEMALES ONLY			
Irregular Periods	☐	☐	☐
Severe Cramps	☐	☐	☐
Excessive Flow	☐	☐	☐
Abnormal PAP Smear	☐	☐	☐
Pregnancy	☐	☐	☐
Cystic Breasts	☐	☐	☐
Monthly Breast Self Exam	☐	☐	☐
MALES ONLY			
Prostate Problems	☐	☐	☐
Lump or Mass in Testicle	☐	☐	☐
Monthly Testicular Self Exam	☐	☐	☐

Have you ever undergone surgery? ☐ Yes ☐ No If yes, describe: _____

Do you take medication regularly? ☐ Yes ☐ No If yes, please list all drugs taken, including over-the-counter drugs, birth control pills, laxatives, sleeping medications and vitamins: _____

Are you allergic to any medications, foods, insect stings? ☐ Yes ☐ No If yes, specify and describe your reaction: _____

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Has your physical activity been restricted during the past five years? ☐Yes ☐No If yes, specify reasons and duration: _____

Have you had difficulty with school, studies, or teachers? ☐Yes ☐No If yes, provide details: _____

Have you had any illness or injury or been hospitalized other than already noted? ☐Yes ☐No If yes, provide details: _____

Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? ☐Yes ☐No

If yes, list other than routine checkups: _____

Have you been rejected for or discharged from military service because of physical, emotional, or other reasons? ☐Yes ☐No

Do you have any questions regarding your health, family history, or other matters that you want to discuss with a staff member of the University Health Center?

Has your physician ever put you on a special diet? ☐Yes ☐No If yes, please explain: _____

Have you received the Quadrivalent Human Papilloma Virus Vaccine (HPV)? ☐Yes ☐No If yes, please give date: _____

Have you ever traveled oversees? ☐Yes ☐No If yes, please complete the following:

Name of Country	Immunizations	Date

Have you ever been ill while overseas (cholera, malaria, typhoid, etc.)? ☐Yes ☐No If yes, please explain: _____

Do you have any further remarks or additional information? _____

PSYCHO/SOCIAL HISTORY – Have you ever had:

☐Anorexia ☐Anxiety ☐Attention Deficit Disorder ☐Bipolar/Mood Disorder ☐Bulimia
☐Depression ☐Learning Disabilities ☐Psychological Counseling

Describe any conditions above with dates: _____

PLEASE LIST PHYSICIANS(S) – Dentist, Ophthalmologist and any other specialists who have provided you with health services:

Name	Practice	Telephone

BY SIGNING THIS, I: 1) affirm all information in this document is correct and complete; 2) agree to inform the University Health Center of any changes in my health and in the information on this form; 3) give my consent that my parents or closest of kin be notified in the case of a situation which the University considers to be a medical emergency; and 4) give consent to be advised/cared for by a nurse, nurse practitioner, or doctor selected by the Cairn University Health Center regarding any medical needs that arise.

_____ _____
STUDENT'S SIGNATURE DATE REVIEWED BY CAIRN UNIVERSITY HEALTH CENTER STAFF MEMBER DATE

_____
AND PARENT, IF A MINOR DATE

PARENTAL CONSENT FOR MEDICAL TREATMENT FOR STUDENTS UNDER THE AGE OF 18

I, _____, give permission for my son/daughter, _____, to be
NAME OF PARENT/GUARDIAN–PLEASE PRINT NAME OF STUDENT–PLEASE PRINT

advised/cared for by a nurse, nurse practitioner, or doctor selected by the Cairn University Health Center regarding any medical needs that arise.

Parent/Guardian's Signature: _____ Date: _____

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