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 confide tial 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:_____ Date of Birth: ____/____/____
LAST FIRST MIDDLE INITIAL

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

Home Phone: _____ Cell Phone: _____

Medical Insurance:

Name of Ins Co _____ ID#_____ Phone#_____ Name of Policy Holder: _____

DOB of Policy Holder:_____

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

DO YOU HAVE:	YES	NO	CURRENT
Anemia	☐	☐	☐
Asthma	☐	☐	☐
Autism	☐	☐	☐
Bleeding Disorder	☐	☐	☐
Celiac	☐	☐	☐
Cardiac Problems	☐	☐	☐
Colitis	☐	☐	☐
Diabetes	☐	☐	☐
Hearing Impairment	☐	☐	☐
High Blood Pressure	☐	☐	☐
Gastrointestinal Issues	☐	☐	☐
Learning Disabilities	☐	☐	☐
Seizures	☐	☐	☐
Syncope	☐	☐	☐
Thyroid Problems	☐	☐	☐
Tumor, Cancer, Cyst	☐	☐	☐
Tuberculosis	☐	☐	☐
Visual Impairment	☐	☐	☐
Other:	☐	☐	☐

Please Explain: _____

	YES	NO	CURRENT
FEMALES ONLY			
Irregular Periods	☐	☐	☐
Severe Cramps	☐	☐	☐
Excessive Flow	☐	☐	☐
Monthly Breast Self Exam	☐	☐	☐
MALES ONLY			
Prostate Problems	☐	☐	☐
Lump or Mass in Testicle	☐	☐	☐
Monthly Testicular	☐	☐	☐

Have you ever undergone surgery or been hospitalized? Yes No If yes, describe: _____

Do you take medication or supplements regularly? Yes No If yes, please list all current medications/supplements 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: _____

Do you carry emergency medication? Epipen, Inhaler etc: _____

Have you had difficulty with school, studies, or teachers? 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: _____

REV. 3/23

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 Uni ersity Health Center?

If yes, please explain:_____

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:

- ☐ ADD/ADHD
- ☐ Bipolar/Mood Disorder
- ☐ Bulimia
- ☐ Depression
- ☐ Eating Disorder
- ☐ Learning Disabilities
- ☐ Nicotine Use
- ☐ Psychological Counseling
- ☐ Schizophrenia
- ☐ Self Harm
- ☐ Substance Abuse
- ☐ Suicide Attempt
- ☐ None of these

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; 5) give consent for any of my pertinent health information, such as my last physical exam, immunization record, chronic health information etc., be released or shared by my health care provider with Cairn University's health care provider when requested, and: 6) release my confidential health information to the leadership of a trip, the hosting sites(s), attending medical personnel, and/or other pertinent leadership for the purpose of assessment and accommodation, and for the well-being of all involved in the trip.

_____ _____

STUDENT'S SIGNATURE DATE

_____ _____

AND PARENT, IF A MINOR DATE REVIEWED BY CAIRN UNIVERSITY HEALTH CENTER STAFF MEMBER

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:_____