

University Health Center

Report of Health History



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: _____ 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: _____
LAST FIRST

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

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

Insurance Company Information: (Please include a photo copy of your current Health Insurance card. Required if traveling with a class.)

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		YES	NO	CURRENT		YES	NO	CURRENT
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hear Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Herpes (genital/oral)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Cancer, Cyst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness, Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Type (if known)	_____		
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY			
Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malaria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal PAP Smear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diseases/Injuries of Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/Faintness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose/Throat Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cystic Breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations (Heart)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Monthly Breast Self Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MALES ONLY			
Eye Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lump or Mass in Testicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gum/Tooth Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Monthly Testicular Self Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Hearing Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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 and prescriptions: _____

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

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 special dietary needs, as directed by a physician? 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 to a foreign country and received immunizations? Yes No If yes, please complete the following:

Name of Country	Immunizations	Date
_____	_____	_____
_____	_____	_____

Have you ever been ill while in a foreign country (cholera, malaria, typhoid, etc.)? Yes No If yes, please explain: _____

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
_____	_____	_____
_____	_____	_____

TRAVEL INFORMATION – Due to the rigor and range of unusual physical and mental challenges that may occur with participation in course related travel, Cairn University requires the following additional information for all participants. Cairn University reserves the right to request additional health information before you participate in course related travel and/or to require a statement from a physician or other health care provider verifying your health.

Have you used any drugs, alcohol, or narcotics in the last 12 months? Yes No If yes, please explain: _____

Do you have any medical and/or psychological condition that is stable now, but that may recur while traveling? Yes No If yes, please explain: _____

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; 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; and 5) release my confidential health information to the leadership of a trip, the hosting site(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 _____

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: _____