

**Student Health Office
Confidential Medical History**

Name (print) _____ Student Cell Phone number () _____

Date of Birth _____ Age _____ Sex: Male / Female Home Address _____

City _____ State _____ Zip _____ Home Phone () _____ Work phone (Mother)() _____

Emergency contact: Name _____
Home phone: _____ Cell number: _____

Cell number (Mother)() _____

Work phone (Father) () _____

Cell number (Father) () _____

Family Physician _____ Address _____ Phone _____

PART I: FAMILY HISTORY

	Name	Occupation	Age (if living)	State of Health	Age and Year of Death	Significant Illness or Cause of Death
Father						
Mother						
Siblings						
Spouse						
Children						

Are there any familial, hereditary or prevalent diseases in your family? (e.g. alcoholism, allergies, cancer, diabetes, high blood pressure, kidney disease, stroke.) List diseases and relationship of those family members. _____

PART II: PERSONAL MEDICAL HISTORY

	YES	NO		YES	NO
Have you Had...			Glaucoma		
Acute infectious Diseases			Hay Fever		
Chicken Pox			Heart Disease (Rheumatic fever, murmur)		
Hepatitis			High Blood Pressure		
Infectious Mononucleosis (Mono)			HIV Infected		
Pneumonia			Kidney or Bladder Disease – Urinary Tract infection		
Tonsilitis			Malaria		
Typhoid			Orthopedic Problem (knee, back)		
Sexually Transmitted Diseases			Prolonged Depression or Anxiety		
Other			Speech, Hearing, Vision Problem		
OTHER DISEASES			Severe Headache (migraine)		
Alcoholism/Drug Addiction			Thrombophlebitis		
Anemia			Thyroid or Endocrine Distrubance		
Anorexia/Bulemia			Tuberculosis		
Asthma			OTHER HEALTH HISTORY (if yes, explain below)		
Cancer			Have you been hospitalized?		
Chronic Bronchitis			Have you had any surgical operations?		
Chronic Skin Disease (eczema, psoriasis)			Are you under medical treatment?		
Convulsions, Seizures (epilepsy)			Do you take any prescribed medicine or injections?		
Dental Problems			Do you have a physical handicap?		
Diabetes			Are you under care of State Rehabilitation?		
Digestive Tract Disease (ulcer, colitis)			Have you been advised to seek psychological help?		
			Have you received psychological care?		

(OVER)

have you traveled outside the US? Where?		
MENSTRUAL HISTORY (females only)		
Problems (cramps, irregular, excessive flow)		
Oral Contraceptives		
Female Infections		
Pregnancies		
Termination of Pregnancy		

Height _____ Weight _____ Blood Pressure _____

ALLERGIC REACTIONS: (penicillin, sulfa, food, immunization, other)

Please comment on all positive answers:

PART III: CONSENT FOR TREATMENT

NURSING SERVICES

Permission is hereby granted to treat the above student as deemed necessary by the staff of Student Health Services at Doane College, for routine medical problems, immunizations and emergencies.

Parent Signature _____ Relationship _____ Date _____

Student Signature _____ Date _____

EMERGENCY MEDICAL TREATMENT

There exists the possibility that your son/daughter/ward may need hospitalization for medical or surgical care while attending Doane College. College authorities will make every effort to contact you immediately. In the event that a parent or guardian is unable to be reached, this authorization will serve as consent for treatment.

***I hereby direct and authorize medical and/or surgical care necessary for my son/daughter by the attending physician and/or surgeon. (A photocopy of this authorization shall be considered as effective and valid as the original).

Parent Signature _____ Date _____

Student Signature _____ Date _____

RELEASE OF INFORMATION

**I understand this information is confidential by the Student Health Office unless my well being as a student would benefit by it being released to responsible college/medical personnel. I hereby grant permission for such release.

Student Signature _____ Date _____

PART IV: INSURANCE INFORMATION

Health Insurance Company _____ City/State _____

Policy number: _____ Group number: _____

**** Please attach a copy of your insurance card. Be sure to include the front and back.**