BELMONT ABBEY COLLEGE HEALTH SERVICES—STUDENT MEDICAL HISTORY

STUDENT INFORMATION **DATE**

NAME (Please Print) Last **First** **Middle**

Date of Birth (MM-DD-YR) ____ - ____ - ____ Gender: M F Class: Fr So Jr Sr College Athlete? Yes /No Team____

Address____ City____ State____ Zip____

Personal Email____ Student Cell Phone____ Nickname____

PARENT/GUARDIAN INFORMATION

Name (s)____ Relationship____ Home Phone____

Work Phone (s)____ Cell Phone (s)____

Address____ City____ State____ Zip____

EMERGENCY CONTACT INFORMATION (In United States)

Name #1 Relationship Phone

Name #2 Relationship Phone

PRIMARY CARE PHYSICIAN

Name____ Phone____

Address____ City____ State____

INSURANCE INFORMATION *(Have student carry insurance card or copy of at all times)* **Purchasing school Insurance? Yes /No**

Insurance Company Policy Number

Name of Insured Insurance ID# Group#

Insurance Co. Address

Insurance Co. Phone Number

ALLERGIES/ADVERSE REACTIONS (medications/insect bite/food/latex/environmental) **None** ☐

Adverse reaction to:	Type of reaction:

MEDICATION(S) (Prescription, allergy injections, FpiPen, contraceptives, over the counter, vitamins, herbal) **None** ☐

Medication:	Taken for:	Dosage:	Frequency:	Date started:	For staff only Date ended:

NAME (Please Print) **Last** **First** **Middle**

MEDICAL HISTORY

Do you have a present or past history of (check all that apply)

- ☐ ADHD/ADD
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma/Inhaler use
- ☐ Back Problems
- ☐ Bleeding/Clotting problems
- ☐ Blood Pressure (high or low)
- ☐ Broken Bones
- ☐ Cancer
- ☐ Cholesterol Elevation
- ☐ Concussion
- ☐ Diabetes
- ☐ Disability/Handicap
- ☐ Dizziness/Fainting
- ☐ Ear Trouble/Hearing Loss
- ☐ Eating Disorder (Anorexia/Bulimia/Over-eating)
- ☐ Eye Problems (besides glasses/contact lenses)
- ☐ Gallbladder Trouble
- ☐ Headache (recurrent)
- ☐ Heart Disease/Problems
- ☐ Heart Murmur
- ☐ Hernia
- ☐ HIV
- ☐ Hypoglycemia (Low blood sugar)
- ☐ Intestinal/Stomach trouble
- ☐ Joint Disease/Injury
- ☐ Kidney Problems/Stones
- ☐ Liver Disease (Hepatitis/Jaundice)
- ☐ Lymph Node enlargement (chronic)
- ☐ Meningitis
- ☐ Mitral Valve Prolapse
- ☐ Mononucleosis
- ☐ Neck Injury
- ☐ Numbness/tingling of arms/legs
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sickle Cell Anemia/trait
- ☐ Sinus Trouble
- ☐ Skin Problems/Eczema/Psoriasis/Acne
- ☐ Sleep Problems
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Urinary Tract Infection
- ☐ Other—*please explain in space below*

Females only:

- ☐ Irregular menstrual cycles
- ☐ Abnormal PAP
- ☐ Pregnancy
- ☐ Significant premenstrual symptoms

Other:

MENTAL/PSYCHOLOGICAL HEALTH

Have you had severe symptoms and/or treatment for: No ☐

☐ Anxiety ☐ Depression ☐ Eating Disorder ☐ Mental or Emotional Disorder ☐ Suicidal thoughts ☐ Suicidal attempts

Please explain and give dates.

HOSPITALIZATIONS (overnight)

None ☐

Reason	Year	Comments

SURGERIES

None ☐

Type	Year	Comments

FAMILY HISTORY

Have parents, siblings, grandparents had any of the following? If adopted and history unknown, check here ____

	Yes	No	Relationship		Yes	No	Relationship
Diabetes	___	___	_____	Sickle cell anemia	___	___	_____
High Blood Pressure	___	___	_____	Thyroid	___	___	_____
Stroke	___	___	_____	Liver disease	___	___	_____
High Cholesterol	___	___	_____	Depression/mental illness	___	___	_____
Heart attack before 55	___	___	_____	Alcoholism	___	___	_____
Cancer (type: _____)	___	___	_____	Other serious illness	___	___	_____

If either parent or sibling is deceased, please list relationship to you, age at death and cause of death_____

NAME: (Please Print) **Last** **First** **Middle**

SOCIAL HISTORY

Please circle below

Tobacco use	Cigarette smoking	Never	Past	Current	Packs per day_____Years smoking_____
	Chewing tobacco or dip	Never	Past	Current	Times per day_____Years_____
	Vape	Never	Past	Current	Times per day_____

Alcohol use Never Past Current

Type: Beer Wine Hard alcohol Amount_____ How Often_____

Recreational Drugs Never Past Current Type:_____

STATEMENT BY STUDENT

I have personally supplied the foregoing information and attest that it is true and complete to the best of my knowledge. I hereby give permission to any doctor, hospital or medical agency to release confidentially to the Belmont Abbey College Health Service any information they may have concerning my medical condition and their professional contact with me. I hereby authorize any necessary medical treatment for myself.

_____ _____

Signature of Student Date

_____

Contact Phone Number (cell)

PARENT/GUARDIANS OF STUDENTS UNDER 18

I hereby authorize any medical treatment for my son/daughter that may be advised or recommended by the physicians, nurse practitioner or healthcare professionals of the Belmont Abbey College Health & Wellness Center.

_____ _____

Signature of Parent/Guardian Date

_____

Contact Phone Number (indicate if cell or home)

COLLEGE POLICY FOR ALL STUDENTS

It is the student's responsibility to keep parents/guardians informed about personal health matters. All reasonable efforts will be made to obtain the student's permission should the College deem it necessary to communicate with the parents/guardians regarding medical concerns.