# Health Record

All information is confidential and is placed in your Personal Health Record.
Please complete and return by July 1.

EARLHAM
SCHOOL of RELIGION

## PERSONAL INFORMATION (Print all information)

Name _____ Date _____

Home Address _____

Phone (_____-_____-_____) Email Address _____

Date of Birth _____ Place of Birth _____

Emergency Notification (Name) _____

Phone (_____-_____-_____) Relationship _____

## FAMILY HISTORY (REQUIRED)

Have any of your parents ever had any of the following? (Check if yes)

| YES | RELATIONSHIP | YES | RELATIONSHIP |
|---|---|---|---|
| __ Tuberculosis* | | __ Epilepsy, Convulsion | |
| __ Diabetes | | __ High Blood Pressure | |
| __ Kidney Disease (kind) | | __ Stroke | |
| __ Heart Disease (kind) | | __ Migraines | |
| __ Arthritis (kind) | | __ Cancer (kind) | |
| __ Stomach Disease (kind) | | __ Blood Disease (kind) | |
| __ Asthma | | | |

*Please read Quantiferon Testing Policy at:earlham.edu/media/4227843/quantiferon-testing-policy.pdf

## PERSONAL HISTORY (REQUIRED)

Indicate if ***you*** have or have ever had any of the following conditions: (Check if yes)

__ Adrenal Condition
__ Altitude Sickness
__ Anemia
__ Anxiety
__ Asthma
__ Back/Neck Problem
__ Bladder Infection
__ Cancer/Tumor/ Leukemia
__ Chest Pain
__ Chicken Pox
__ Deafness/Hearing Loss
__ Depression
__ Diabetes
__ Digestive Problems
__ Dizziness
__ Drug/Alcohol Dependency
__ Eating Disorder
__ Fainting/Passing Out
__ Frostbite
__ Head Injury/Concussion
__ Heart Disease
__ Heart Murmur
__ Heart Rhythm Problem
__ Hepatitis/Liver Disease
__ Hernia
__ High Blood Pressure
__ HIV/AIDS
__ Hyperventilation
__ Hypothermia
__ Insomnia
__ Joint or Bone Disease
__ Kidney Disease/Stone
__ Malaria
__ Measles (Rubeola)
__ Migraine Headache
__ Mononucleosis
__ Mumps
__ Phlebitis
__ Polio
__ Rheumatic Fever
__ Rubella (German Measles)
__ Seizures/Epilepsy
__ Sickle Cell Anemia
__ Skin Problems
__ Stomach Ulcer/GERD
__ Stroke
__ Suicide Attempt
__ Sun Sensitivity
__ Sunstroke/ Heat Exhaustion
__ Thyroid Condition
__ Tonsillectomy
__ Tuberculosis
__ Epilepsy, Convulsion
__ High Blood Pressure
__ Stroke
__ Migraines Cancer (kind)
__ Blood Disease (kind)

### List Surgeries

_____
_____
_____
_____
_____
_____

Please complete both sides of this form and email it to healthservices@earlham.edu

## Please answer the following. You may use an additional sheet of paper if necessary.

1. Please provide detailed information on all positive responses about your personal history from the previous page. Indicate, also, when the medical condition or symptom occurred and if the condition is current.

2. Please describe any other illness, medical problem, hospitalization, or surgery not identified on the previous page, including when it occurred and if the condition is current.

3. Are you allergic to any medications? If yes, what medication(s) and what is your reaction?

4. Are there any other medications you have been told to avoid? If yes, what medication(s) and why?

5. List any medications, supplements or vitamins you are taking, including psychiatric and over-the-counter medication.
   Medication Condition Dosage (size & frequency) Current Side Effects

6. Are you allergic to dust, molds, pollens, insect stings? __yes __no If yes, what? Explain the severity and means of treatment.

7. Have you any food allergies or other dietary restrictions? __yes __no If yes, what? (If you have food allergies, direct any questions you might have to the Food Service Director when you arrive on campus.)

8. Have you lived or traveled overseas? __yes __no If yes, where and when?

9. Has your physical activity been restricted during the past 5 years, including your ability to run, lift and climb? Is it now restricted? Give details, including the reason and duration.

10. Do you wear glasses or contact lenses? __yes __no Which, and for what reason?_____

11. Have you ever been under the care of a psychologist, psychiatrist, or counselor? __yes __no If yes, when? For what reason?

12. Please evaluate your general health by circling one: Excellent Good Fair Poor

13. Is there anything else about you that you would like us to know in order to provide for your health care?

Personal Physician's Name _____ Phone _____

Personal Dentist's Name _____ Phone _____

Personal Counselor/Psychiatrist's Name _____ Phone_____

## STATEMENT OF AUTHORIZATION

I authorize Earlham College Health Services to administer medical and surgical services including immunization, allergy injection, and to perform emergency procedures, as necessary, or refer to duly licensed medical personnel when indicated (including transfer to local hospitals). I authorize emergency medical treatment while participating on off campus programs. I hereby state that I am capable of safely participating in vigorous physical activity offered through physical education, intramural, and intercollegiate athletics unless otherwise noted in this health inventory.

**Signature of Student**_____ **Date** _____