CONCORDIA
UNIVERSITY

HEALTH HISTORY FORM for HEALTH SERVICES

Last Name ______________________________ **First Name** ______________________ **MI** ________

Date of Birth _______________ (day/month/year) **Student my.CU ID** G00___________________

Year and Semester of Entry: Year _____ Semester □ Fall □ Spring □ Summer 1 □ Summer 2

CONCORDIA UNIVERSITY HEALTH SERVICES REQUIREMENTS AND RECOMMENDATIONS

Required - Rubeola (Measles) vaccine documentation Oregon State Law (see *Certificate of Immunization* details).

Recommended - All immunizations are up to date (see www.cdc.gov/vaccines).

Recommended - Up to date wellness exam /screening tests (check with your health care provider).

Recommended - If you have health insurance please know how to access your insurance.

PERSONAL HISTORY

Name you prefer to be called______________________Place of Birth ________________________________

Mailing Address ____

City ______________________________ State ___ Zip ________ Country ___________________________

Phone____________________________ Email ____

Male ____ Female ____ Height _________ Weight _________

Health Insurance Company _______________________________________ If no insurance, check here _____

Are you under the care of a physician? No _____ Yes _____ (please specify) ______________

Do you take prescription meds, OTC meds, vitamins, herbal preparations? _____No ____ Yes (please list)

Name____________________________ Purpose____

Name____________________________ Purpose____

Are you allergic to any medications? __ No ___ Yes *(Please specify)*______________________________
____

Do you use tobacco? No _____Yes _____ Concerns? ________ Would you like help quitting? _______

Do you drink alcohol? No _____Yes ______ Concerns? ________ Would you like information? _______

Have you ever been hospitalized or had surgery? _____ No ___ Yes

Date _______________________ Reason ____

Date _______________________ Reason ____

(continued on next page)

Have you ever had or do you currently have any of the following conditions?

___Alcohol / Drug Problems
___Allergies (other than medications)
Specify_______________
___Anemia
___Asthma
___Chronic Back Problems
___Broken bones
___Cancer
___ Colitis
___ Cystitis
___ Congenital Problem
___Diabetes Type 1
Type 2
___Duodenal /Stomach Ulcer
___Eczema
___Epilepsy
___Hearing Loss
___ Heart Disease
___Hepatitis
___Hernia
___ High Blood Pressure
___ High Cholesterol
___Kidney Disease
___Meningitis
___Menstrual Problems
___ Mononucleosis
___ Mental Disorder
___Rheumatoid Arthritis
___Thyroid Disorder
___Toxic Shock
___Tuberculosis
___Other
Specify_______________

Do you have any physical activity restrictions? *(Describe)*____

Immunizations (list dates or attach copy of your immunization record)

1. Measles/Mumps/Rubella (MMR) **REQUIRED** 2 doses 1st dose___________________ 2nd dose___________________
2. Tetanus (Td / Tdap) most recent ________________________
3. Varicella (chickenpox) 2 doses 1st dose_______________ 2nd dose_________________ Had Disease __________
4. Hepatitis A (Hep A) 2 doses 1st dose_______________ 2nd dose__________________
5. Hepatitis B (Hep B) 3 doses 1st dose_______________ 2nd dose_________________ 3rd dose _______________
6. Human Papillomavirus (HPV) 3 doses 1st dose ________________ 2nd dose ________________ 3rd dose_______________
7. Meningococcal (MCV) ________
8. Influenza (seasonal flu) ______________ Influenza (H1N1flu) _______________

FAMILY CONTACT INFORMATION

Name & please circle / parent, guardian, spouse, friend ____

Address____

City ___________________________________ State _____ Zip _____________ Country _____________

Phone _______________________________

Within the past year, has a close friend/member of your family died, been hospitalized, or been seriously ill?

_______ No _______ Yes Describe ____

Student Signature ____ Date ___________________

Revised 01-Jan-2010/br