



CONCORDIA
UNIVERSITY

HEALTH HISTORY FORM for STUDENT 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

HEALTH SERVICES REQUIREMENTS AND RECOMMENDATIONS

Required - Measles (**Rubeola**) documentation is a state of Oregon law (details *Certificate of Immunization*).

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 – please learn about your health insurance (as a beginning review the web site).

Health Insurance Company _____ No insurance? Check here _____

PERSONAL HISTORY

Name you prefer to be called _____ Country of Birth _____

CU mailing address _____

City _____ State ____ Zip _____ Country _____

Phone _____ email _____

Male ____ Female ____ Height _____ Weight _____

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

Prescription meds, OTC meds, vitamins, herbal preparations, supplements? ____ No ____ Yes (please list)

Name _____ Purpose _____

Name _____ Purpose _____

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? _____

Do you have physical activity restrictions? (please describe) _____

(continued on next page)

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

Date _____ Reason _____

Date _____ Reason _____

Have you ever had or currently have any of the following conditions? Yes (circle) No

Alcohol / Drug problems	Diabetes Type 1 / Type 2	Kidney disease
Allergies (other than medications) Specify _____	Eczema	Meningitis
Anemia	Epilepsy	Menstrual problems
Asthma	Gastro intestinal problems	Mental health problems
Chronic back problems	Hearing loss	Mono
Chronic bladder infections	Heart problems	Rheumatoid arthritis
Broken bones	Hepatitis	Thyroid disorder
Cancer	Hernia	Toxic shock
Congenital problem	High blood pressure	Tuberculosis
	High cholesterol	Other (specify _____)

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

1. Measles/Mumps/Rubella (MMR) **REQUIRED** 2 doses # 1 _____ # 2 _____
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) _____

FAMILY CONTACT INFORMATION

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

Address _____

City _____ State _____ Zip _____ Country _____

Phone _____

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

_____ No _____ Yes Describe _____

Student Signature _____ Date _____