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)	Eczema	Meningitis
Specify_____	Epilepsy	Menstrual problems
Anemia	Gastro intestinal problems	Mental health problems
Asthma	Hearing loss	Mono
Chronic back problems	Heart problems	Rheumatoid arthritis
Chronic bladder infections	Hepatitis	Thyroid disorder
Broken bones	Hernia	Toxic shock
Cancer	High blood pressure	Tuberculosis
Congenital problem	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 _____

Revised Jan 2012/br