REPORT OF MEDICAL HISTORY

(Please print in black ink) To be completed by student

Last Name (Please Print) First Name Middle Name Social Security Number (Last four digits)

Permanent Address City State Zip Code Area Code/Phone Number

Date of Birth (mm/dd/yyyy): _____ Gender (circle one): Male Female Marital Status: M S Other

CLASS YOU ARE ENTERING (Circle one)
Fr. So. Jr. Sr.

Previously enrolled here: Yes No If Yes, Dates _____

Semester Entering FALL SPRING
SUMMER 1 SUMMER 2 YEAR 20_____

Health Insurance (Name and Address of Company) Area Code/Phone Number

Name of Policy Holder Social Security Number Date of Birth Employer

Policy or Certificate Number Group Number

Is this an HMO/PPO/Managed Care Plan? Yes No

Emergency Contact Information

Name Relation Cell Phone Number Home Phone

Name Relation Cell Phone Number Home Phone #

The following health history is confidential, does not affect your admission status and may only be shared with other health care professionals on an as needed basis to ensure that the student receives required and/or requested treatment and care as necessary. Please attach additional sheets for any items that require fuller explanation.

FAMILY AND PERSONAL HEALTH HISTORY

(Print in black ink) To be completed by student

Has any person, in your immediate family, had any of the following?

	Yes	No	Relationship		Yes	No	Relationship		Yes	No	Relationship
High blood pressure				Cholesterol or blood fat disorder				Alcoholic/drug problems			
Stroke				Diabetes				Psychiatric illness			
Heart Attack before age 55				Glaucoma				Suicide			
Blood or clotting disorder				Cancer (type)				other			

Have you ever had or have you now: (please check at right of each item and if yes, indicated year of first occurrence)

	Yes	No	Year		Yes	No	Year		Yes	No	Year		Yes	No	Year
High blood pressure				Hay fever				Jaundice or hepatitis				Kidney stone			
Rheumatic fever				Allergy injection therapy				Rectal disease				Protein or blood in urine			
Heart trouble				Arthritis				Severe or recurrent abdominal pain				Hearing loss			
Pain or pressure in chest				Concussion				Hernia				Sinusitis			
Shortness of breath				Frequent/severe headaches				Easily fatigued				Severe menstrual cramps			
Asthma				Dizziness or fainting spells				Anemia or Sickle Cell Anemia				Irregular periods			
Pneumonia				Severe head injury				Eye trouble other than glasses/contact lenses				Sexually transmitted disease			
Chronic cough				Paralysis				Bone or joint deformity				Blood transfusion			
Head or neck radiation treatments				Disabling depression				Knee problems				Alcohol use			
Tumor or cancer (specify)				Excessive worry of anxiety				Recurrent back pain				Drug use			
Malaria				Ulcer				Neck injury				Anorexia/Bulimia			
Thyroid trouble				Intestinal trouble				Back injury				Smoke 1+ pack cigarettes/weekly			
Diabetes				Pilonidal cyst				Broken bone (specify)				Regular exercise			
Serious skin disease				Frequent vomiting				Kidney infection				Wear seat belt			
Mononucleosis				Gall bladder trouble or gallstones				Bladder infection				Other (specify)			

Please list any drugs, medicines, birth control pills, vitamins, and minerals (prescription and nonprescription) you use and indicate how often you use them.

Name _____ Use_____ Dosage_____

Name _____ Use_____ Dosage_____

FAMILY AND PERSONAL HEALTH HISTORY-CONTINUED (Please print in black ink) To be completed

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet)

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has

Adverse Reactions To:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and why.)			
Has your academic career been interrupted due to physical or			
Is there loss or seriously impaired function of any paired organs? (Please describe)			
Other than for a routine check up, have you seen a physician			
Have you ever had any serious illnesses or injuries other than those already noted? (Specify			

IMPORTANT INFORMATION ... PLEASE READ AND COMPLETE

STATEMENT BY STUDENT (OR PARENT/GUARDIAN IF STUDENT UNDER AGE 18)

A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my I understand that the information is strictly confidential and will not be released to anyone without my written consent, otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the of the Student Health Service.

C) I am aware that the Student Health Service charges for some services and I may be billed through the College Cashier if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Cashier and for of incurred charges. I am responsible for filing outpatient charges with insurance.
I also acknowledge that my responsibility to MHC is unaffected by the existence of insurance coverage.

Signature of Student _____Date_____

Signature of Parent/Guardian, if student under age 18_____ Date_____