

NORTHWEST NAZARENE UNIVERSITY  
Health Questionnaire and Medical History  
CONFIDENTIAL INFORMATION

Term Applied: \_\_\_\_\_ Date: \_\_\_\_\_ Sex:  Male  Female  
Name: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  
Widow Last First Middle  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_

IN CASE OF EMERGENCY CONTACT:

Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_  
Relationship:  Parent  Guardian  Spouse  Other \_\_\_\_\_

INFORMATION:

Health Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_  
Name of Responsible Person: \_\_\_\_\_  
Social Security # of Responsible Person: \_\_\_\_\_ Birthdate of Responsible Person \_\_\_\_\_  
Are you now under treatment for present illness, injury or problem?  Yes  No  
(If yes, explain and/or send physician's statement.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHYSICAL EDUCATION:

Please check the appropriate statement:  Physically able to take P.E.  
 Should be excused from some activity  
 Should be excused from all activity

Nature of problem to be excused. This must be verified by family physician. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

It is a **STATE/ADMISSION REQUIREMENT** of all entering students to submit proof or copy of the following:

**PLEASE CHECK ONE:**

1. \_\_\_\_\_ Verification of administration of MMR (Mumps/Measles/Rubella) vaccine: \_\_\_\_\_ DAY MONTH YEAR  
Physician's signature \_\_\_\_\_
2. \_\_\_\_\_ Copy of Immunization Records (Contact your public school or private physician).
3. \_\_\_\_\_ Birthdate of 1957 or before (If born before 1957, vaccine not necessary).

If you are unable to obtain the above documentation, **it will be necessary for you to receive an MMR vaccine from a private physician or local health center, before you may complete the Admission process. STATEMENT OF INCIDENCE OF HAVING THE DISEASE(S) IS NOT ADEQUATE DUE TO DIFFICULTY OF DIAGNOSIS.** Please submit copy of blood test/lab work if having the disease made it unnecessary to receive the vaccine.

**If opposed to immunizations due to religious or medical reasons, please attach documentation to that effect to this Health Questionnaire.**

LAST TETNUS IMMUNIZATION: \_\_\_\_\_ POLIO IMMUNIZATION \_\_\_\_\_  
DAY MONTH YEAR DAY MONTH YEAR

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

(OVER)

## UNIVERSITY ENTRANCE MEDICAL HISTORY

*This very confidential information will be sent directly to our Health Center. No one will have access to it except the college nurse, your physician and the Director of Counseling in Student Development.*

### FAMILY HISTORY

	Age	Condition of health <i>(If deceased, list cause)</i>
Father		
Mother		
Brothers/Sisters		
Spouse		
Children		

Has any member of your family, including Grandparents had any of the following? Please mark with:

"F" - Father, "M" - Mother, "G" - Grandparent.

- |   |  |
|---|--|
| <input type="checkbox"/> Allergies      | <input type="checkbox"/> Glaucoma            |
| <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Heart Problems      |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cancer         | <input type="checkbox"/> Epilepsy            |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Urinary problems    |
| <input type="checkbox"/> Mood Disorders | <input type="checkbox"/> Ulcer/stomach       |
| <input type="checkbox"/> Depression     | <input type="checkbox"/> Anxiety problems    |

YOUR HEALTH HISTORY: PLEASE MARK ANY OF THE FOLLOWING YOU NOW HAVE OR EVER HAVE HAD.

- |   |                                      |   |  |   |  |
|---|--------------------------------------|---|--|---|--|
| <input type="checkbox"/> Allergies      | <input type="checkbox"/> Dizziness   | <input type="checkbox"/> Hearing loss     | <input type="checkbox"/> German Measles    | <input type="checkbox"/> Painful Urination  | <input type="checkbox"/> Sore Throats    |
| <input type="checkbox"/> Anorexia       | <input type="checkbox"/> Acne        | <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Joint Pain        | <input type="checkbox"/> Scarlet Fever      | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Mononucleosis  | <input type="checkbox"/> Measles     | <input type="checkbox"/> Hernia           | <input type="checkbox"/> Earaches          | <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Fainting        |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Mumps       | <input type="checkbox"/> Chicken Pox      | <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Eye Problems       | <input type="checkbox"/> Pneumonia       |
| <input type="checkbox"/> Night Sweats   | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Polio            | <input type="checkbox"/> Rectal Bleeding   | <input type="checkbox"/> Venereal Disease   | <input type="checkbox"/> Crying Spells   |
| <input type="checkbox"/> Hemorrhoids    | <input type="checkbox"/> Asthma      | <input type="checkbox"/> Colds            | <input type="checkbox"/> Yellow Jaundice   | <input type="checkbox"/> Nervous Exhaustion | <input type="checkbox"/> AIDS            |
| <input type="checkbox"/> Depression     | <input type="checkbox"/> Insomnia    | <input type="checkbox"/> Anxiety problems |  |   |  |

Have you been hospitalized for any serious illness, accident, or surgery? Write in your most recent hospitalizations and include the following information:

Date	Operation or Illness	Hospital	City & State

Have you ever been involved in personal counseling in the last five years?  Yes  No

Do you smoke?  Yes  No # of packs  # of years  Chew Tobacco?  Yes  No

Do you drink alcohol?  Yes  No How often?

Have you ever used psychedelic or addictive drugs with or without prescription?  Yes  No

If so, what was it called: \_\_\_\_\_

**MEDICATIONS:** *Please check the medications that you are taking or are allergic to*

Taking: <input type="checkbox"/>	Allergic to: _____	Medicine: _____	Taking: <input type="checkbox"/>	Allergic to: _____	Medicine: _____
<input type="checkbox"/>	_____	Ampicillin	<input type="checkbox"/>	_____	Demerol
<input type="checkbox"/>	_____	Antihistamines	<input type="checkbox"/>	_____	Erythromycin
<input type="checkbox"/>	_____	Aspirin	<input type="checkbox"/>	_____	Penicillin
<input type="checkbox"/>	_____	Codeine	<input type="checkbox"/>	_____	Sulfa
<input type="checkbox"/>	_____	Cold tablets	<input type="checkbox"/>	_____	Tetracycline
**Other:	_____	When: _____	Why: _____		
**Other:	_____	When: _____	Why: _____		

**TESTS YOU HAVE HAD?**  
(Check and enter year)

19\_\_ AIDS Blood Test

19\_\_ Chest X-ray

19\_\_ Kidney X-ray

19\_\_ Colon X-ray

19\_\_ Gallbladder X-ray

19\_\_ EKG

19\_\_ Other: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_