

NORTHWEST NAZARENE UNIVERSITY

Health Questionnaire and 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.

INFORMATION

Term Applied: _____ Date: _____ Sex: ___Male ___Female
Name: _____ Marital Status: ___Single ___Married ___Divorced ___Widow
Last First Middle
Social Security #: _____ Date of Birth: _____ Present Height: _____ Present Weight: _____
Address: _____
Street/Apt.# City State Zip

IN CASE OF EMERGENCY CONTACT:

Name: _____ Phone # (____) _____
Relationship: Parent Guardian Spouse Other: _____

INSURANCE:

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.** _____

MMR VACCINE STATEMENT:

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: _____

FAMILY HISTORY

	Age	Condition of health (If deceased, list cause)
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.

_____ Allergies	_____ Glaucoma
_____ Arthritis	_____ Heart Problems
_____ Asthma	_____ High Blood Pressure
_____ Cancer	_____ Epilepsy
_____ Diabetes	_____ Urinary problems
_____ Depression	_____ Anxiety
Ulcer/stomach problems	

YOUR HEALTH HISTORY

PLEASE MARK ANY OF THE FOLLOWING YOU NOW HAVE OR EVER HAVE HAD.

<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"/> 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"/> 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"/> Fainting
<input type="checkbox"/> Sexually Transmitted Diseases (STD's)		<input type="checkbox"/> AIDS	<input type="checkbox"/> Depression	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Anxiety problems		
<input type="checkbox"/> Nervous Exhaustion	<input type="checkbox"/> Yellow Jaundice	<input type="checkbox"/> Allergies	<input type="checkbox"/> Indigestion				

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 If yes, please give reason:

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
 When? _____
 Drug Name: _____ Length of Time: _____
 Reason: _____

1. List all allergies and reactions:

2. List all medications you are currently taking and dosage prescribed by physicians:

TESTS YOU HAVE HAD

<input type="checkbox"/> Ultrasound	<input type="checkbox"/> EKG	<input type="checkbox"/> Upper GI	<input type="checkbox"/> ECG	<input type="checkbox"/> Lower GI
<input type="checkbox"/> X-rays	<input type="checkbox"/> AIDS Blood Test	<input type="checkbox"/> Other Blood Tests		
<input type="checkbox"/> Other: _____				

Please give date(s) of test(s) and reason for testing: _____
