MEDICAL HISTORY QUESTIONNAIRE

Updated 4/2/2019

La Sierra University | Student Wellness Services

ALL STUDENTS MUST COMPLETE AND SUBMIT THIS FORM TO THE STUDENT WELLNESS SERVICES, PRIOR TO THE START OF THEIR FIRST QUARTER. This form will be used only as an aid to provide necessary health care.

PERSONAL INFORMATION: Country of Birth: _____ Student ID: _____ Age: _____

Name: _____ Gender:_____ Date of Birth: _____
Last First Middle

Local Address: _____ Cell phone:_____
Street City State Zip Code

Physician's Name: _____ Phone: _____ Fax: _____

EMERGENCY CONTACT: Name: _____ Relationship:_____
Last First

Cell phone:_____ Work phone:_____ email: _____

PERSONAL HEALTH HISTORY:

Height: _____ Weight: _____ **Drug Allergies:** _____

Are you currently under medical treatment? ☐ Yes ☐ No If yes, why? _____

What medications are you taking regularly (including birth control, ADHD medication, or antidepressants)?

_____ Injuries (Date & Reason) _____

What medical conditions have required care in the past five years? _____

Hospitalizations (Date & Reason) _____ Operations (Date & Reason) _____

Have you been involved in personal counseling in the past five years? ☐ Yes ☐ No

Please indicate which of the following conditions/diseases you or your family members have or have had previously. Indicate family as: Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM), Grandfather (GF).

	Student		Family Member				Student		Family Member		
	Past	Present	Past	Present	Who		Past	Present	Past	Present	Who
ADD/ADHD	☐	☐	☐	☐	_____	Epilepsy	☐	☐	☐	☐	_____
Alcohol dependency	☐	☐	☐	☐	_____	Excessive fatigue	☐	☐	☐	☐	_____
Allergic rhinitis	☐	☐	☐	☐	_____	Heart disease	☐	☐	☐	☐	_____
Anemia	☐	☐	☐	☐	_____	Hepatitis	☐	☐	☐	☐	_____
Anxiety	☐	☐	☐	☐	_____	Hernia	☐	☐	☐	☐	_____
Arthritis	☐	☐	☐	☐	_____	High blood pressure	☐	☐	☐	☐	_____
Asthma	☐	☐	☐	☐	_____	Infectious mononucleosis	☐	☐	☐	☐	_____
Back trouble	☐	☐	☐	☐	_____	Inflammatory Bowel Disease	☐	☐	☐	☐	_____
Bladder/Kidney infection	☐	☐	☐	☐	_____	Malaria	☐	☐	☐	☐	_____
Bleeding disorder	☐	☐	☐	☐	_____	Meningitis	☐	☐	☐	☐	_____
Blood transfusion	☐	☐	☐	☐	_____	Migraines	☐	☐	☐	☐	_____
Bronchitis	☐	☐	☐	☐	_____	Obesity	☐	☐	☐	☐	_____
Cancer	☐	☐	☐	☐	_____	Pneumonia	☐	☐	☐	☐	_____
Chicken pox	☐	☐	☐	☐	_____	Sexually transmitted infections	☐	☐	☐	☐	_____
Concussion	☐	☐	☐	☐	_____	Sinusitis	☐	☐	☐	☐	_____
Depression	☐	☐	☐	☐	_____	Thyroid problems	☐	☐	☐	☐	_____
Diabetes	☐	☐	☐	☐	_____	Tonsillitis	☐	☐	☐	☐	_____
Drug dependency	☐	☐	☐	☐	_____	Tuberculosis or exposure to TB	☐	☐	☐	☐	_____
Eating disorder	☐	☐	☐	☐	_____	Vaginitis	☐	☐	☐	☐	_____
Emphysema	☐	☐	☐	☐	_____	Other: _____	☐	☐	☐	☐	_____

Is there any other information about your medical history or current medical needs we should know?

_____

STUDENT PERMISSION FOR TREATMENT:

To the best of my knowledge, the information given herein is correct. Also I hereby give consent to any therapeutic, diagnostic, minor operative and/or emergency procedures as may be deemed necessary by the La Sierra University Student Wellness Services' health care providers. This includes referral to private physicians and other facilities. This consent is given in advance to allow the staff of Student Wellness Services to exercise their best judgment in providing prompt health care services to me.

_____ _____
Student Signature Date

GUARDIAN PERMISSION FOR TREATMENT (For students under the age of 18):

To the best of my knowledge, the information given herein is correct. Also I hereby give consent to any therapeutic, diagnostic, minor operative and/or emergency procedures that may be rendered to said minor, as may be deemed necessary by the La Sierra University Student Wellness Services' health care providers. This includes referral to private physicians and other facilities. This consent is given in advance to allow the staff of Student Wellness Services to exercise their best judgment in providing prompt health care services to said minor.

_____ _____
Guardian Signature Date

LA SIERRA UNIVERSITY
STUDENT WELLNESS SERVICES
4500 RIVERWALK PARKWAY, RIVERSIDE, CA 92505
Phone: (951) 785-2200 Fax: (951) 785-2263

LAST NAME:
FIRST NAME:
ID #:
BIRTHDAY: