Alvernia University
Health & Wellness Center
Veronica Hall—Lower Level
610-568-1467 /fax 610-796-8422

MEDICAL HISTORY FORM

All medical information is CONFIDENTIAL.
The information provided is strictly for the use of Health Services and will not be released to anyone without your written consent.

(Print) LAST NAME ______ FIRST NAME ______ MIDDLE ______ SSN ______

HOME ADDRESS (STREET & NUMBER) ______ CITY ______ STATE ______ ZIP ______

HOME PHONE NUMBER ______ CELL PHONE NUMBER ______

Gender ☐ MALE ☐ FEMALE ______ DATE OF BIRTH Is the student 18 years of age or older? ☐ YES ☐ NO

If NO, please sign as follows: "I hereby give my permission for Alvernia University's Health Services medical staff to provide medical services to the above-named student as needed."

______
SIGNATURE OF PARENT OR GUARDIAN

EMERGENCY CONTACT: NAME ______ DAY TIME PHONE ______ CELL PHONE ______ RELATIONSHIP ______

INSURANCE

** THIS INFORMATION IS NECESSARY FOR ANY LAB TESTS THAT MAY BE SENT OUT OR IN CASE OF AN EMERGENCY**
ALL STUDENTS MUST HAVE HEALTH INSURANCE

POLICY INFORMATION

Insurance Co. Name:______

Ins. Co. Address:______

Ins. Co. Phone #:______

ID#:______ Group #:______

If HMO, list name of Primary Care Physician:______

Phone #:______ Fax #:______

CARRIER INFORMATION

Name of person carrying insurance:______

Address:______

Phone #:______ SSN:______

Employer: ______

Address:______

Phone #:______

ALLERGIES

Are you allergic to any medication(s)? ☐ YES ☐ NO If yes, list medication(s) and reaction(s):______

Do you have any food/environmental allergies? ☐ YES ☐ NO If yes, please list:______

MEDICATIONS

Are you currently taking daily medications? ☐ YES ☐ NO If yes, please list (include prescription drugs, vitamins, contraceptives, over-the-counter medications taken regularly, etc.)

______

______

FAMILY HISTORY

Relation	Age	General Health	Past/Present Serious Illness	If deceased, age and cause of death
Father				
Mother				
Sibling				

(Print) LAST NAME FIRST NAME MIDDLE SSN

PERSONAL HISTORY

	YES	NO
Chicken Pox		
Measles		
Mononucleosis		
Mumps		
Rheumatic Fever		
Tuberculosis		
Diabetes		
Kidney Disease		
Gallbladder Problems		
Diarrhea (recurrent)		
Back Problems		

	YES	NO
Asthma		
Chronic Cough		
Shortness of Breath		
High Blood Pressure		
Heart Disease		
Heart Murmur		
ADD/ADHD		
Alcohol/Drug Dependency		
Anxiety		
Depression		
Eating Disorder		

	YES	NO
Concussion		
Dizziness/Fainting		
Headache (recurrent)		
Skin Condition		
FEMALES ONLY		
Excessive Flow		
Irregular Periods		
Severe Cramps		
MALES ONLY		
Testicle Problems		
Hernia		

Do you have an illness or condition not listed above, for which you are now being treated? If yes, please specify:

Have you ever had any significant injuries, e.g. head injury, fractures, or any other trauma? If yes, please specify type of injury and date of occurrence.

Please list types and dates of any hospitalizations and/or surgeries.

SOCIAL HISTORY

Do you smoke? ☐ YES ☐ NO If yes, how often (packs per day)?

Do you chew smokeless tobacco? ☐ YES ☐ NO If yes, how often?

Do you use recreation drugs? ☐ YES ☐ NO If yes, type and frequency?

Do you drink alcohol? ☐ YES ☐ NO If yes, average number of drinks at one time? Number of times/week?

THIS MUST BE SIGNED BY THE STUDENT: I certify that the information entered is complete and accurate.

Student Signature Date

IMMUNIZATION RECORD

The following immunizations are REQUIRED by Alvernia University. (Please specify month and year)

DPT (Diphtheria/Pertussis/Tetanus)	1	2	3	4	5
TD (Tetanus/Diphtheria) within 10 years of attendance/every 10 years as an adult				1	2
*Meningococcal Vaccination REQUIRED BY PA LAW FOR STUDENTS LIVING IN RESIDENCE HALLS (Must be within the last 5 years)					1
MMR (Measles/Mumps/Rubella)	OR date disease diagnosed by doctor			1	2
Measles (2 doses, after 12 mos. & after age 5) *Exempt if born before 1957*	OR Blood Titer (copy of lab report must be attached)			1	2
Mumps	History of Rubella not acceptable				1
Rubella					1
Polio (oral or trivalent)		1	2	3	4

*A waiver may be signed for the Meningitis Vaccine, but proof of the vaccine or the waiver must be submitted to the Health & Wellness Center prior to moving into a residence hall.

The following immunizations are recommended by Alvernia University, AND REQUIRED FOR ALL NURSING, OT, AT STUDENTS.

Hepatitis B	1	2	3
Varicella (Chicken Pox) or date of disease		1	2

Physician Stamp & Phone Number