



## 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

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

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	CARRIER INFORMATION
Insurance Co. Name: _____	Name of person carrying insurance: _____
Ins. Co. Address: _____	Address: _____
Ins. Co. Phone #: _____	Phone #: _____ SSN: _____
ID#: _____ Group #: _____	Employer: _____
If HMO, list name of Primary Care Physician: _____	Address: _____
Phone #: _____ Fax #: _____	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		YES	NO		YES	NO
Chicken Pox			Asthma			Concussion		
Measles			Chronic Cough			Dizziness/Fainting		
Mononucleosis			Shortness of Breath			Headache (recurrent)		
Mumps			High Blood Pressure			<b>FEMALES ONLY</b>		
Rheumatic Fever			Heart Disease			Excessive Flow		
Tuberculosis			Heart Murmur			Irregular Periods		
Diabetes			ADD/ADHD			Severe Cramps		
Kidney Disease			Alcohol/Drug Dependency			STD/STI		
Gallbladder Problems			Anxiety			<b>MALES ONLY</b>		
Diarrhea (recurrent)			Depression			Testicle Problems		
Back Problems			Eating Disorder			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)

	1	2	3	4	5
DPT (Diphtheria/Pertussis/Tetanus)					
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.

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

Physician Stamp & Phone Number