

Emory & Henry

COLLEGE

Medical Information Form

Dear Emory & Henry Student:

This Medical Information Form is to be completed by you and your physician. It is important to answer all the questions regarding your medical history before your physical examination. After you and your physician have completed this form, **please mail it to the Emory & Henry Dean of Students Office as quickly as possible.** This information will not affect your admission status. The contents of this form are needed to provide quality health care services while you attend Emory & Henry. This information is strictly for the use of the Health Services and will not be released to anyone without your knowledge and consent. **You will not be allowed to register, attend classes, or be seen at the Health Center unless this form is completed and returned.**

Patient Information

LAST NAME (PRINT) _____ FIRST NAME _____ MIDDLE _____ SOCIAL SECURITY NO. _____

HOME ADDRESS (NUMBER & STREET) _____ CITY/TOWN _____ STATE _____ ZIP CODE _____ HOME PHONE NO. _____

Date of Birth _____ Place of Birth _____ Age _____ Sex _____ Race _____ Marital Status _____

Mother's name and work no. _____ Father's name and work no. _____

Insurance: _____

Group Number: _____

Policy Number: _____

Address: _____

Telephone: _____

Policy holder name: _____

Admission status:

First-year

Transfer

Readmission

Special

Date of Entrance:

Fall

Spring

Summer

20 ____

Family History

	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH	HAVE ANY OF YOUR RELATIVES EVER HAD THE FOLLOWING:			
					YES	NO	RELATIONSHIP	
Father					Tuberculosis			
Mother					Diabetes			
Brother(s)					Kidney Disease			
					Arthritis			
Sister(s)					Stomach Disease			
					Asthma, Hay Fever			
					Epilepsy, Convulsions			

Personal History

*Please answer all questions. **Comment on all "yes" answers on the additional sheet.***

HAVE YOU HAD?	YES	NO	YES	NO	YES	NO			
Scarlet Fever			Frequent Anxiety			Pain/Pressure in Chest			
Measles			Frequent Depression			Chronic Cough			
German Measles			Worry or Nervousness			Palpitations (Heart)			
Mumps			Recurrent Headaches			High or Low Blood Pressure			
Chicken Pox			Recurrent Colds						
Malaria			Head Injury with Unconsciousness			Rheumatic Fever or Heart Murmur			
Gum or Tooth Trouble									
Sinusitis			Asthma			Disease or Injury of Joints			
Eye Trouble			Tuberculosis						
Ear, Nose, Throat Trouble			Shortness of Breath			"Trick Knee, Shoulder," etc.			
Surgery			Allergy						
Appendectomy			Penicillin			Back Problems			
Tonsillectomy			Sulfonamides			Tumor, Cancer, Cyst			
Hernia Repair			Serum			Jaundice			
Other			Foods (types)			Stomach or Intestinal Trouble			
Insomnia			Other						
Recurrent Hernia			Venereal Disease			Gallbladder Trouble or Gallstones			
Dizziness, Fainting			Frequent Urination						
Albumin/Sugar in Urine			Recent Gain or Loss of Weight			Female Only	Irregular period		
Diabetes								Severe Cramps	
			ADHD/ADD				Excessive Flow		

Has your physical activity been restricted during the past five years? yes no
 (Give reasons and durations.)

Do you take any medication? If yes, give name and dosage on attached sheet. yes no

Have you had any illnesses or injuries requiring hospitalization? (Give details.) yes no

Have you received any treatment or counseling for a nervous condition, personality or character disorder, or emotional problems? (Give diagnosis and dates of treatment.) yes no

Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years (other than routine checkups)? yes no

Have you been rejected or discharged from military service because of physical, emotional, or other reasons? (If so, give reasons.) yes no

 Student's Signature Date

 Physician's Signature (Acknowledging Review) Date

Immunizations

*Please complete all blanks. A second MMR (measles, mumps, and rubella) immunization is required or proof of immunization by titer: If you were born before 1957 or have had the diseases, please note on the MMR blanks below. However, you are still required to have a current tetanus and tuberculin. *Required.*

* Measles (Rubeola)		
	DATE OF FIRST INJECTION	DATE OF SECOND INJECTION
* Mumps		
	DATE OF FIRST INJECTION	DATE OF SECOND INJECTION
* Rubella (German Measles)		
	DATE OF FIRST INJECTION	DATE OF SECOND INJECTION
* Polio		Please write date of last dose.
	DATE	
* Diphtheria		Please write date of last dose.
	DATE	
* Tetanus		This dose has to be within the past ten years.
	DATE	
* Tuberculin PPD Required	DATE _____ RESULT _____	This test must have been done within the past year.
Hepatitis B Required for Athletic Trainers	#1 #2 #3	
	DATE	
Meningococcal Vaccine		
Others		
Rubella titer (not required if 2 doses of MMR)		
	DATE/TITER	

Please mail the completed four-page form to:
 Dean of Students Office
 Emory & Henry College
 PO Box 947 • Emory, Virginia 24327-0947
 Telephone: 276-944-4121

You must have this form completed *before* registration.

A parent or guardian of a student under 18 years of age must sign the following statement to allow the college to authorize treatment.

The staff of Emory & Henry College has my permission to authorize emergency medical treatment for our son/daughter

_____ .

Parent
Guardian
Date