

NAME (Please Print) Last _____ **First** _____ **Middle** _____

MEDICAL HISTORY

Do you have a present or past history of (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Eye Problems (besides glasses/contact lenses) | <input type="checkbox"/> Numbness/tingling of arms/legs |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Gallbladder Trouble | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headache (recurrent) | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease/Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma/Inhaler use | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sickle Cell Anemia/trait |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Bleeding/Clotting problems | <input type="checkbox"/> HIV | <input type="checkbox"/> Skin Problems/Eczema/Psoriasis/Acne |
| <input type="checkbox"/> Blood Pressure (high or low) | <input type="checkbox"/> Hypoglycemia (Low blood sugar) | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Intestinal/Stomach trouble | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Joint Disease/Injury | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cholesterol Elevation | <input type="checkbox"/> Kidney Problems/Stones | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Liver Disease (Hepatitis/Jaundice) | <input type="checkbox"/> Other— <i>please explain in space below</i> |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lymph Node enlargement (chronic) | Females only: |
| <input type="checkbox"/> Disability/Handicap | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Irregular menstrual cycles |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Abnormal PAP |
| <input type="checkbox"/> Ear Trouble/Hearing Loss | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Eating Disorder (Anorexia/Bulimia/Over-eating) | <input type="checkbox"/> Neck Injury | <input type="checkbox"/> Significant premenstrual symptoms |

Other: _____

MENTAL/PSYCHOLOGICAL HEALTH

Have you had severe symptoms and/or treatment for: **No**

- Anxiety Depression Eating Disorder Mental or Emotional Disorder Suicidal thoughts Suicidal attempts

Please explain and give dates. _____

HOSPITALIZATIONS (overnight) **None**

Reason	Year	Comments

SURGERIES **None**

Type	Year	Comments

FAMILY HISTORY

Have parents, siblings, grandparents had any of the following? If adopted and history unknown, check here _____

	Yes	No	Relationship		Yes	No	Relationship
Diabetes	___	___	_____	Sickle cell anemia	___	___	_____
High Blood Pressure	___	___	_____	Thyroid	___	___	_____
Stroke	___	___	_____	Liver disease	___	___	_____
High Cholesterol	___	___	_____	Depression/mental illness	___	___	_____
Heart attack before 55	___	___	_____	Alcoholism	___	___	_____
Cancer (type: _____)	___	___	_____	Other serious illness	___	___	_____

If either parent or sibling is deceased, please list relationship to you, age at death and cause of death _____

NAME: (Please Print) **Last** **First** **Middle**

SOCIAL HISTORY

Please circle below

Tobacco use	Cigarette smoking	Never	Past	Current	Packs per day _____	Years smoking _____
	Chewing tobacco or dip	Never	Past	Current	Times per day _____	Years _____
	Vape	Never	Past	Current	Times per day _____	

Alcohol use	Never	Past	Current			
	Type: Beer	Wine	Hard alcohol	Amount _____	How Often _____	

Recreational Drugs	Never	Past	Current	Type: _____
---------------------------	-------	------	---------	-------------

STATEMENT BY STUDENT

I have personally supplied the foregoing information and attest that it is true and complete to the best of my knowledge. I hereby give permission to any doctor, hospital or medical agency to release confidentially to the Belmont Abbey College Health Service any information they may have concerning my medical condition and their professional contact with me. I hereby authorize any necessary medical treatment for myself.

Signature of Student _____
Date

Contact Phone Number (cell)

PARENT/GUARDIANS OF STUDENTS UNDER 18

I hereby authorize any medical treatment for my son/daughter that may be advised or recommended by the physicians, nurse practitioner or healthcare professionals of the Belmont Abbey College Health & Wellness Center.

Signature of Parent/Guardian _____
Date

Contact Phone Number (indicate if cell or home)

COLLEGE POLICY FOR ALL STUDENTS

It is the student's responsibility to keep parents/guardians informed about personal health matters. All reasonable efforts will be made to obtain the student's permission should the College deem it necessary to communicate with the parents/guardians regarding medical concerns.