Personal Health History

NOTE:
Please see Union's bulletin for a description of Student Health.

PERSONAL INFORMATION

Date _____ Social security # _____ – _____ – _____

Name (last, first, middle) _____ Telephone _____

Mailing address _____

Birthdate: month _____ day _____ year _____ Birthplace _____

Marital status: ○ Single ○ Married ○ Divorced ○ Widowed Sex: ○ Male ○ Female

Age _____ Height: feet ____ inches _____ Weight _____

Have you attended another college? ○ Yes ○ No

Parent's or guardian's name _____ Telephone _____

Parent's mailing address _____

YOU ARE ON "HOLD" UNTIL THE FOLLOWING UNION COLLEGE STUDENT HEALTH REQUIREMENTS ARE MET:

- Documented proof of current tetanus immunization within the past ten years.
- Documented proof of immunity to red measles (rubeola). Each student born after 12/31/56 must show proof of two red measles (rubeola) vaccines after their first birthday or a blood test (titre) proving their immunity to the disease.
- Documented proof of immunity to German Measles (Rubella). Each student born after 12/31/56 must show proof of having German Measles (Rubella) vaccine after their first birthday or a blood test (titre) proving their immunity to the disease.
- Documented proof of current negative TB (Tuberculosis) skin test (TST) within one year prior to admission. If the TB skin test is positive, you must show proof of having a normal chest X-ray within one year prior to admission.

IMMUNIZATION RECORD

Please attach the following (required):

	DATE	BOOSTER		
Measles, Mumps, Rubella (MMR) two shots required after first birthday	MM/DD/YY	MM/DD/YY		
Tetanus (TD) or (TDAP) (within 10 years)	MM/DD/YY			
Polio series	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
Hepatitis B series	MM/DD/YY	MM/DD/YY	MM/DD/YY	
Meningococcal vaccine	MM/DD/YY	MM/DD/YY		
TB Skin Test (TST) within one year, if positive, check x-ray within one year	MM/DD/YY	Results _____		
Chest x-ray	MM/DD/YY	Results _____		

HEALTH HISTORY

	RECENT (AT PRESENT OR WITHIN PAST YEAR)		PAST (MORE THAN ONE YEAR AGO)	
	YES	NO	YES	NO
A) EAR, NOSE AND THROAT				
Do you presently have or have you had...				
1. Trouble with hearing?	○	○	○	○
2. Severe difficulty breathing through your nose?	○	○	○	○
3. Frequent sore throats or colds?	○	○	○	○
B) EYES				
Do you presently have or have you had...				
1. Need of eye glasses or contact lenses?	○	○	○	○
2. Loss of vision or damaged function of one or both eyes?	○	○	○	○
Describe _____				
C) DENTAL				
Do you presently have or have you had...				
1. Gum or tooth trouble?	○	○	○	○
D) RESPIRATORY				
Do you presently have or have you had...				
1. Loss of or damaged functioning of a lung?	○	○	○	○
2. Asthma?	○	○	○	○
3. Pneumonia?	○	○	○	○
4. Tuberculosis?	○	○	○	○

HEALTH HISTORY (CONTINUED)

	RECENT (AT PRESENT OR WITHIN PAST YEAR)		PAST (MORE THAN ONE YEAR AGO)	
	YES	NO	YES	NO
E) CARDIOVASCULAR				
Do you presently have or have you had...				
1. A heart murmur that the doctor said is serious?	○	○	○	○
2. High blood pressure?	○	○	○	○
3. Rheumatic fever?	○	○	○	○
F) GASTROINTESTINAL				
Do you presently have or have you had...				
1. Consistent pain in the abdomen?	○	○	○	○
2. Frequent episodes of vomiting?	○	○	○	○
3. Trouble with gas, heartburn, sour stomach, bloating, or indigestion?	○	○	○	○
4. Stomach or duodenal ulcers?	○	○	○	○
5. Recurrent diarrhea?	○	○	○	○
6. Jaundice or hepatitis?	○	○	○	○
7. Any serious or disabling stomach or bowel problems?	○	○	○	○
If yes, specify?_____				
G) GENITOURINARY				
Do you presently have or have you had...				
1. Damaged function of a kidney?	○	○	○	○
2. Frequent infections in the kidney or bladder?	○	○	○	○
3. A sexually transmitted disease or infection?	○	○	○	○
4. Frequent urination?	○	○	○	○
Females only				
5. Irregular periods?	○	○	○	○
6. Severe cramps?	○	○	○	○
7. Excessive flow?	○	○	○	○
8. Any medicine for menstrual problems?	○	○	○	○
If yes, specify?_____				
H) ENDOCRINE				
Do you presently have or have you had...				
1. An over-active thyroid?	○	○	○	○
2. An under-active thyroid?	○	○	○	○
3. Diabetes?	○	○	○	○
I) NEUROLOGY				
Do you presently have or have you had...				
1. A nervous breakdown?	○	○	○	○
2. Hospitalized for problems with your nerves?	○	○	○	○
3. Seizures in the past 5 years?	○	○	○	○
4. Recurring severe headaches?	○	○	○	○
5. Blackout spells (or episodes of confusion)?	○	○	○	○
J) MUSCULOSKELETAL				
Do you presently have or have you had...				
1. Back stiffness or pain which interferes with your normal activity for more than 7 days?	○	○	○	○
2. Troublesome joint stiffness, pain or swelling?	○	○	○	○
3. Rheumatoid arthritis?	○	○	○	○
4. An amputation of an arm or leg?	○	○	○	○
K) SKIN				
Do you presently have or have you had...				
1. Troublesome acne?	○	○	○	○
2. Persistent or recurrent skin rash?	○	○	○	○
3. Mole(s) that changed in size or color?	○	○	○	○

HEALTH HISTORY (CONTINUED)

	RECENT (AT PRESENT OR WITHIN PAST YEAR)		PAST (MORE THAN ONE YEAR AGO)	
	YES	NO	YES	NO
L) HEMATOLOGY-BLOOD				
Do you presently have or have you had...				
1. Serious blood reaction to a drug treatment?	○	○	○	○
2. Anemia?	○	○	○	○
3. Excessive bruising?	○	○	○	○

	YES	NO
M) EMOTIONAL		
1. Do you feel lonely or depressed most of the time?	○	○
2. Would you say that your stress level is very high?	○	○
3. Have you ever seriously contemplated or attempted suicide?	○	○
4. Have you obtained help from a mental health professional?	○	○
5. Do you feel hopeless?	○	○
6. Are you in considerable emotional pain?	○	○
7. Do you feel that you need to do something to change things in your life?	○	○
8. Do you feel bad about yourself most of the time?	○	○
9. Would you find counselling useful for any of your problems?	○	○
10. Have you ever received a mental health diagnosis?	○	○
If yes, than what was the diagnosis?_____		
N) GENERAL MEDICAL		
1. Do you take any medication or injections, prescribed or over the counter, or medicinal herbs? If yes, list the names of all medications and shots prescribed and non-prescribed which you are taking regularly _____	○	○
2. Have you ever been admitted to a hospital as an in-patient?	○	○
3. Have you had surgery? If yes, list all operations and the year of each. _____	○	○
4. Have you had serious injuries? If yes, list injury (injuries) and year of each. _____	○	○
5. Has a physician told you that you should have an operation that you still need?	○	○
6. Are you sensitive to any drugs? If yes, please specify _____	○	○
7. Other allergies?_____	○	○
O) CHILDHOOD DISEASES		
Have you had...		
1. Chickenpox?	○	○
2. Measles (Red)?	○	○
3. Measles (German)?	○	○
4. Mumps?	○	○
5. Scarlet Fever?	○	○
6. Other?_____	○	○
P) GENERAL PROFILE		
1. Do you feel that your current state of health is interfering with your normal activity?	○	○
2. Have you in the past been under a physician's care for other than minor illnesses? If yes, specify?_____	○	○
3. Are you presently under a physician's care for other than minor illnesses? If yes, specify?_____	○	○
4. Must you limit your physical activity?	○	○
5. Do you consider yourself to have a physical handicap? If yes please specify. What accomodations do you need?_____	○	○
6. When was your last physical exam?_____		
7. When was your vision last checked?_____		
8. When was your last dental check up?_____		
9. Do you have any health problems which were not mentioned in this questionnairre or additional comments which you would like to add? If yes, please specify. _____	○	○

NOTE:
For any prescription medicine (shots) which you wish Student Health to administer, you must bring a written order signed by your physician. This order must name the medicine and include the amount to be given, the frequency and method of administration, and how long this medication is to be continued.

NOTE:

Union College requires all full-time (12 or more credit hours) students to have medical insurance. If you do not have coverage on your own, or through your parents, you must purchase a policy through Union College (see the student medical insurance form).

ADDRESS:

Admissions Office
Union College
3800 South 48th Street
Lincoln, NE 68506-4386

CONTACT:

www.ucollege.edu
enroll@ucollege.edu
P 800.228.4600
P 402.486.2504
F 402.486.2566

UNION COLLEGE

PERSONAL HEALTH HISTORY

I CERTIFY THAT THE ANSWERS TO THE QUESTIONS ABOVE ARE CORRECT TO THE BEST OF MY KNOWLEDGE. I also understand that Student Health is an important, integral part of the student services program at Union College. Union College, through its student services, is committed to the traditional Seventh-day Adventist concept of the harmonious development of the physical, the mental and the spiritual. Student Health works closely with the residence hall deans, counselors and teachers to help the students realize their full potential. Therefore, the student's medical record is open to the student and members of the student services personnel as necessary, just as are other files of the student personnel services.

Signed _____ Date ____/____/____

Treatment authorization must be signed by a parent or guardian if the student is under age 19. I hereby authorize and give my consent to the health authorities of Union College or any licensed practitioner to perform upon or administer to ____(NAME OF STUDENT)____ any reasonably necessary medical or surgical treatment. I also give permission to administer whatever anesthetic may be necessary or advisable during the medical or surgical procedures. This authorization is intended to cover emergency treatment, immunizations, injections, and minor operations and procedures.

In the event of indicated major surgery or major treatment, the college authorities or physicians are not hereby excused from attempting to contact me before relying upon this authorization. This authorization does not entitle the service or physician to render any medical or surgical treatment without the student's personal consent, unless the student is unable to give consent (i.e. unconsciousness).

In addition, I give authorization for the student to receive mental health counseling services.

Permission is also granted to release information from the student's medical record to a person or persons designated by the college when, in the opinion of the director of Student Health, release of specific information is deemed necessary. This permission is good only while the student is attending the above college and only until the student has attained his or her nineteenth birthday.

Signature _____ Date ____/____/____

Relationship to student _____ Telephone _____

Address _____