Health History

(fill out both sides of this page)

Name: _____ **Date of Birth:**_____**Age**___
Last name First name Middle

Cell Phone: _____

Home Address: _____

City: _____ State:_____Zip: _____ Country: _____

Past Medical History

Have you have any of the following? *If yes, please indicate if the condition is current or in the past?*

Conditions	Present	Past (date)	No	**Conditions**	Present	Past (date)	No
Seasonal Allergies				Hepatitis			
Anemia (type)				Hearing Impairment			
Anxiety/ Panic Attacks				High Blood Pressure			
Asthma				Kidney Disease			
Bleeding Disorder				Mononucleosis			
Cancer				Physical Disability			
Chicken Pox				Pneumonia			
Depression/ Bipolar				Spine Disorders/ Scoliosis			
Diabetes Mellitus				Stomach/ Intestinal Problems			
Eating Disorders				Thyroid Problems			
Epilepsy/ Seizures				Visual Impairment			
Headaches				Other (name)			
Heart Problems/ Murmur				Other (name)			

Allergies (*medications, foods, environmental*): _____ **Reaction:** _____

1. Have you been hospitalized or had any surgeries? If yes, list with date:

_____

2. Do you take any prescription or non-prescription medications including vitamins, supplements, and herbs? No ☐ Yes ☐

List them all (including inhalers and EpiPens): _____

3. Please list any disabilities for which Wesleyan College may need to provide you with special assistance:

_____

4. Do you have a history or mental illness or mental health problems? If yes, When? _____

Explain: _____

5. Have you ever seen a psychiatrist, psychologist, or therapist?_____Date/s_____

If yes, please ask your medical or mental health professional to send a copy of your records to Wesleyan Health Services.

I, (print name)_____, give my permission for my mental health and medical records to be shared between Health Services and Counseling Department at Wesleyan College.

Student's Signature_____Date_____

Name:_____ **Date of Birth:** _____
Last name First name Middle name

Answer Yes or No to the following questions and provide additional information for "yes" answers.

1. Do you have any chronic medical problems (diabetes, anemia, epilepsy, etc.)? If yes, please list:

   _____

2. Have you had an injury (dislocation /broken bones, muscle, tendon, joint)? If yes, please list and give dates of injuries:

   _____

3. Have you ever had a head injury or concussion? No ☐ Yes ☐ Date(s)_____

4. Have you ever had a seizure? No ☐ Yes ☐ Type of seizure_____ Date(s)_____
5. Do you have frequent or severe headaches? No ☐ Yes ☐
6. Have you ever passed out during or after exercise? No ☐ Yes ☐
7. Have you ever been dizzy during or after exercise? No ☐ Yes ☐
8. Have you ever had chest pain or shortness of breath during or after exercise? No ☐ Yes ☐
9. Have you ever been diagnosed with a heart murmur? No ☐ Yes ☐
10. Has a physician ever denied or restricted your participation in sports for any heart problems? No ☐ Yes ☐
11. Has anyone in your family died of heart problems or sudden death before the age of 50? No ☐ Yes ☐

12. Have you ever had heat or muscle cramps? No ☐ Yes ☐ Date(s) _____
13. Do you wear any prosthetic devises or use any special equipment (pads, braces, foot orthotics, mouth guards)? No ☐ Yes ☐
14. Do you have any eye or vision problems? No ☐ Yes ☐ Do you wear glasses, contacts, or protective eyewear? No ☐ Yes ☐

15. Do you have any skin problems (rash, infections, fungus, eczema, and warts)? No ☐ Yes ☐ If yes, please list:_____

    _____

16. Do you have any missing or non-functioning organs? (kidney, eye, spleen etc.) No ☐ Yes ☐ If yes, please list:_____

    _____

17. Have any immediate family members (parents, brothers or sisters) had these conditions. (Circle any that apply)
    High Blood Pressure | Stroke | Bleeding Disorders | Asthma | Tuberculosis | Heart Disease | Diabetes | Epilepsy | Migraine
18. Do you have any other problems not listed above? Describe: _____

_____

I, (print name)_____, hereby state that to the best of my knowledge, my answers are accurate.
I consent to release my entire medical record (including physical exam) to the: Nursing Dept. ☐ Athletic Dept. ☐

Student Signature_____ **Date**_____

Parent's Signature ***(if student is under age 18)***_____ **Date**_____

I, (print name)_____acknowledge I have received a copy of the Wesleyan College Privacy Practice Agreement and have had the opportunity to ask questions.

Student Signature_____ **Date**_____