BETHUNE COOKMAN UNIVERITY
STUDENT HEALTH SERVICES
MEDICAL HISTORY FORM

(386) 481-2920 Fax (386) 481-2923 studenthealth@cookman.edu

SECTION A **PERSONAL DATA** Expected date of entry_____

Please Print Clearly

NAME_____ Date of Birth_____
Last First Middle

HOME ADDRESS_____
Number/Street City State Zip

SOCIAL SECURITY# _____-_____-_____ SEX_____ HEIGHT_____ WEIGHT_____

STUDENTS CONTACT_____
E-mail Phone

EMERGENCY CONTACT

_____
Name Relationship Phone

SECTION B **HEALTH HISTORY**

Please check if you or your family (father, mother, sisters, brothers or grandparents) have been treated in the past for any of the following and indicate the year:

	Self Only		Self	Family
Antibiotics for Dental Work (due to heart)	_____	Alcohol/Drug Use	_____	_____
Blood Clot/Phlebitis	_____	Allergy/hay fever	_____	_____
Chicken Pox	_____	Anemia/Blood Disease	_____	_____
Digestive Disorders	_____	Arthritis/Joint, Bone Disease	_____	_____
Head Injury	_____	Asthma	_____	_____
Hepatitis	_____	Cancer	_____	_____
Hives	_____	Diabetes (type)	_____	_____
Hypoglycemia	_____	Epilepsy/Seizures	_____	_____
Lyme Disease	_____	Heart Murmur/Disease	_____	_____
Malaria	_____	High Blood Pressure	_____	_____
Mononucleosis	_____	Migraines	_____	_____
Bladder Infections	_____	Psychological Problems	_____	_____
Rheumatic Fever	_____	Sickle Cell Disease/Trait	_____	_____
Scarlet Fever	_____	Thyroid Disease	_____	_____
STD's	_____	Tuberculosis	_____	_____
TMJ (jaw problems)	_____	other	_____	_____
Transfusions	_____			
Use Tobacco	_____			

Do you have any ALLERGIES (medications, insect stings, environmental factors, foods)? Please list.

_____

Are you CURRENTLY under the care of a physician or clinical practitioner for **any** condition (s)? Please list and provide documentation.

_____

List all MEDICAL Issues/Concerns

_____

List all CURRENT Medications including birth control, vitamins, herbal preparations, supplements?

_____

List operations and/or hospitalizations including the reason and year.

_____

SECTION C **MEDICAL CONSENT**

I have personally supplied and reviewed the above information and attest that it is true and complete to the best of my knowledge. I understand that this information is strictly confidential and will not be released to anyone without my written consent, unless permitted by law.

I hereby grant permission to Bethune-Cookman University Student Health Services to render medical care, which, in their judgment is deemed advisable; to make necessary referrals; to release medical information necessary for appropriate care and treatment and to authorize hospitalization when recommended in the event of illness or accident.

Signed_____Date_____/_____/_____

Signed _____Date_____/_____/_____
Parent/guardian IF under 18 and single