UNIVERSITY OF Redlands
2017 - 2018

Medical History Questionnaire

All students must complete this form and return it to the
Student Health Center by July 24, 2017.
health_center@redlands.edu ● 1200 E. Colton Ave. Redlands, CA. 92373-0999
Tele: (909) 748-8021 ● Fax: (909) 335-5117

This information is required of all full-time students. It will be kept as part of your confidential medical records at the Student Health Center and will be used only as an aid to provide necessary health care. Please complete as accurately as possible.

Name: _____ **Student ID:** _____
Date of Birth: _____ **Country of Birth:** _____
Address: _____ **Citizenship:** _____
City: _____ **State:** _____ **Zip code:** _____ **Gender:** _____

Allergies
Medication Allergies: _____
Food Allergies: _____ Other Allergies: _____

Emergency Contact
Name: _____ Day Phone: (_____)_____ Eve Phone: (_____)_____
Relationship to Student:_____ Cell Phone: (_____)_____

Personal & Family Health History
Height: _____ Weight: _____
Are you currently under medical treatment? ☐ Yes ☐ No If yes, why?_____
Please give name and phone number of physician: _____
Do you take medication daily? ☐ Yes ☐ No If yes, please list (include birth control, ADD medication, antidepressants): _____
_____
Have you ever had surgery? ☐ Yes ☐ No If yes, please describe, include dates: _____

Please indicate which of the following conditions/diseases you or your family members have or have had previously. Please indicate who in your family has had the conditions/diseases. Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM), Grandfather (GF), Aunt (A), Uncle (U), Children (C).

	Student		Family Member				Student		Family Member		
	Past	Present	Past	Present	Who		Past	Present	Past	Present	Who
ADD/ADHD	☐	☐	☐	☐	_____	Emphysema	☐	☐	☐	☐	_____
Alcohol dependency	☐	☐	☐	☐	_____	Epilepsy	☐	☐	☐	☐	_____
Allergic rhinitis	☐	☐	☐	☐	_____	Excessive fatigue	☐	☐	☐	☐	_____
Anemia	☐	☐	☐	☐	_____	Heart Disease	☐	☐	☐	☐	_____
Anxiety	☐	☐	☐	☐	_____	Hepatitis	☐	☐	☐	☐	_____
Arthritis	☐	☐	☐	☐	_____	Hernia	☐	☐	☐	☐	_____
Asthma	☐	☐	☐	☐	_____	High blood pressure	☐	☐	☐	☐	_____
Back trouble	☐	☐	☐	☐	_____	Infectious mononucleosis	☐	☐	☐	☐	_____
Bladder/Kidney infection	☐	☐	☐	☐	_____	Malaria	☐	☐	☐	☐	_____
Bleeding disorder	☐	☐	☐	☐	_____	Meningitis	☐	☐	☐	☐	_____
Blood transfusion	☐	☐	☐	☐	_____	Migraines	☐	☐	☐	☐	_____
Bronchitis	☐	☐	☐	☐	_____	Obesity	☐	☐	☐	☐	_____
Cancer	☐	☐	☐	☐	_____	Pneumonia	☐	☐	☐	☐	_____
Chronic inflammatory bowel disorder	☐	☐	☐	☐	_____	Sexually transmitted infections	☐	☐	☐	☐	_____
						Sinusitis	☐	☐	☐	☐	_____
Chicken pox	☐	☐	☐	☐	_____	Thyroid problems	☐	☐	☐	☐	_____
Concussion	☐	☐	☐	☐	_____	Tonsillitis	☐	☐	☐	☐	_____
Depression	☐	☐	☐	☐	_____	Tuberculosis or exposure to TB	☐	☐	☐	☐	_____
Diabetes	☐	☐	☐	☐	_____	Ulcer	☐	☐	☐	☐	_____
Drug dependency	☐	☐	☐	☐	_____	Vaginitis	☐	☐	☐	☐	_____
Eating disorder	☐	☐	☐	☐	_____	Other: _____	☐	☐	☐	☐	_____

Please indicate whether or not you:

Are a consistent seat belt user? Yes ☐ No ☐
Concerned about your weight? Yes ☐ No ☐ If yes, list methods of weight loss or gain _____
A cigarette smoker? Yes ☐ No ☐ If yes, packs per day_____ Number of years smoking _____
An alcohol consumer? Yes ☐ No ☐ If yes, how many drinks per day? _____ per week?_____ per month? _____
A marijuana user? Yes ☐ No ☐ If yes, how much per day? _____ per week? _____ per month? _____

Is there any other information about your medical history or current medical needs we should know?

_____
_____

To the best of my knowledge, the information given herein is correct. Also I hereby give my permission for such diagnostic, therapeutic, minor operative, and emergency procedures as may be deemed necessary by the University's Student Health Center Staff. This includes referral to private physicians and other facilities.

_____ _____ _____ _____
Student Signature Date Parent/Guardian signature (if student under 18) Date

ADDITIONAL AUTHORIZATION ON BACK MUST BE COMPLETED IF STUDENT WILL BE UNDER 18 AS OF August 15, 2017

Authorization for Treatment of a Minor:
(Required for those students under the age of 18 as of August 15, 2017)

I (we) the undersigned parent/guardian of _____
Do authorize medical care at agencies deemed necessary for the best interest of this student as determined by the staff of the University of Redlands. Such care may include, but is not limited to:

x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is to be rendered under the auspices of a physician or nurse practitioner. It is understood this authorization (in accordance with Section 25.8 of the Civil Code of California) is given in advance of any specific diagnosis, treatment or hospital care required and is given to provide authority of power on the part of our aforesaid agent(s) to give specific consent to and for all such diagnosis, treatment, and /or hospital care which a physician or nurse practitioner, meeting all the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable. Furthermore, I (we) authorize any hospital which has provided treatment to the above-mentioned minor to surrender physical custody of such minor to the above-mentioned agent(s) upon the completion of treatment (pursuant to Section 1283 of the Health and Safety Code of California).

_____ _____ ___/___/_____
Signature of Parent/Guardian Relationship to Student Date