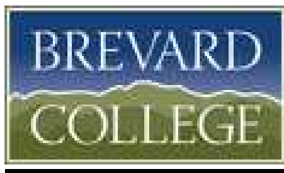

MEDICAL HISTORY FORM

TO THE STUDENT: The information which you provide will be used as an aid in administering any necessary care while you are a student at Brevard College. All students' medical records are kept in the clinic and are confidential.

If you have medical, emotional, physical, or learning challenges, you MAY want to contact the Office for Students with Special Needs and Disabilities at 828-884-8131

Please complete all items on this form. *Please print or type.*

Last Name First Name Middle *Social Security Number
Home Address (No. and Street) City State ZIP Phone Date of Birth ______________ Sex: / M / F Marital Status: / S / M / D Entering: / Fall / Spring / Summer Previously Enrolled? _________ When? _________

REPORT OF MEDICAL HISTORY

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. *Please attach additional sheets for any items that require fuller explanation.*

FAMILY & PERSONAL HEALTH HISTORY

Has any person, related by blood, had any of the following:

	Yes	No	Relationship
High Blood Pressure			
Stroke			
Cancer (type:)			
Heart attack before 55			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Relationship
Blood or clotting disorder			
Alcohol problems			
Psychiatric illness			
Suicide			

Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year
High Blood pressure			
Rheumatic fever			
Heart trouble			
Pain or pressure in chest			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Tuberculosis			
Tumor or cancer (specify)			
Malaria			
Thyroid trouble			
Serious skin disease			
Alcohol/drug use			
Sexually trans-mitted disease			

	Yes	No	Year
Mononucleosis			
Hay fever			
Head or neck radiation treatments			
Arthritis			
Concussion			
Frequent or severe headache			
Dizziness or fainting spells			
Severe head injury			
Paralysis			
Epilepsy/Seizures			
Disabling depression			
Excessive worry or anxiety			
Ulcer (duodenal or stomach)			
Intestinal trouble			
Pilonidal cyst			

	Yes	No	Year
Self-induced vomiting			
Frequent vomiting			
Gall bladder trouble or gallstones			
Jaundice or hepatitis			
Rectal disease			
Severe or recurrent abdominal pain			
Hernia			
Easy fatigability			
Anemia or Sickle Cell Anemia			
Eye trouble besides need glasses			
Bone, joint or other deformity			
Shoulder dislocation			
Knee problems			
Recurrent back pain			
Neck injury			

	Yes	No	Year
Back injury			
Broken bones			
Kidney infection			
Bladder infection			
Kidney stone			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Severe menstrual cramps			
Irregular periods			
Blood transfusion			
Smoke 1+ pack cigarettes/week			
Diabetes			
Anorexia/Bulimia			
Allergy infection therapy			

***Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.**

Please describe any conditions or disabilities that would exclude participation in physical education. ________________

____

Do you exercise three or more times per week? □ Yes □ No Do you use a seatbelt on a regular basis □ Yes □ No

Please list any drugs, medicines, birth control pills, vitamins and minerals (prescription and nonprescription) you use and indicate how often you use them.

Name _________________ Use _______________ Dosage __________

Name _________________ Use _______________ Dosage __________

Name _________________ Use _______________ Dosage __________

Name _________________ Use _______________ Dosage __________

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet). Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Have you ever been a patient in any type of hospital? (When, where, and why.)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there loss or seriously impaired function of any paired organs? (Please describe)			
Other than for a routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe).			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details.)			

Personal History:	Yes	No	Chest/Heart/Lungs:	Yes	No		Yes	No
Lost weight in last year?	☐	☐	Shortness of Breath	☐	☐	Chest Pain or Pressure	☐	☐
On a special diet?	☐	☐	Back Pain	☐	☐	Frequent Cough	☐	☐
Satisfied w/ weight?	☐	☐	Abnormal Heartbeat	☐	☐	Wheezing	☐	☐
Difficulty sleeping?	☐	☐						

Injury History/PMH: Have you ever injured or had a problem with: If multiple, give most recent

		Yes	No	
Neck		☐	☐	If yes, when? Date:_______________
Shoulder	R L	☐	☐	If yes, when? Date:_______________
Elbow	R L	☐	☐	If yes, when? Date:_______________
Wrist/Hand/Finger	R L	☐	☐	If yes, when? Date:_______________
Back		☐	☐	If yes, when? Date:_______________
Hip	R L	☐	☐	If yes, when? Date:_______________
Knee	R L	☐	☐	If yes, when? Date:_______________
Ankle/Foot/Toes	R L	☐	☐	If yes, when? Date:_______________
Broken Bone		☐	☐	If yes, when? Date:_______________

Women:	Yes	No	Men:	Yes	No
Menstrual Difficulty	☐	☐	Loss of Testicle	☐	☐
Ovarian Cysts	☐	☐	Other Problem:__________________		

Other Gyn Problems:____________________ ______________________________

____

	Yes	No
Do you have any condition of disease not listed on this form?	☐	☐

If yes, Explain:____

____

Please list any previous surgeries (including dates):____

____

____

I, ____ (Print Name) the undersigned, herewith:

A) Understand that I must refrain from physical activities, practice or play while ill or injured, whether or not receiving medical treatment until discharged from treatment or given permission by the clinical practitioner to restart participation, despite continuing treatment.
B) Understand that having passed the physical examination does not necessarily mean that I am physically qualified to engage in physical activity and/or athletics, but only that the examiner did not find a medical reason to disqualify at the time of said examination.
C) Give permission to the BC Medical Staff and Medical Doctors involved in my care to discuss medical conditions pertaining to said care in regards to physical activity and/or athletic participation.

STATEMENT BY STUDENT: I have personally supplied the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent unless by Court order. However, if I should be ill or injured and unable to sign the appropriate forms, I hereby give my permission for Student Health Services or Athletic Training Department to release information from my medical record to a physician, hospital, or other medical agency involved in providing me with emergency treatment and/or medical care.

Student Signature: ____ Date: _______________________

Print Guardian Name: ____

Parent/Guardian Signature: ___________________________________ Date: ________________________
(**only for students that are under 18 years of age**)