

Health History Form

To be completed by student and filled out in pen.

Name _____ Date of Birth ____/____/____ M F
Last First Middle Month Day Year

Permanent Address _____

City _____ State _____ Zip/Postal Code _____ Country _____

Email _____

Single Married Undergraduate Graduate Telephone (____) _____

Person to be notified in emergency _____ Relationship _____

Telephone: Day (____) _____ Evening (____) _____ Cell (____) _____

FAMILY MEDICAL HISTORY: Among your blood relatives is there any past or present illness from the following?

	YES	NO	RELATIVE		YES	NO	RELATIVE		YES	NO	RELATIVE
Allergy				Epilepsy				Psychiatric Disease			
Arthritis				High Blood Pressure				Tuberculosis			
Cancer				Heart Disease				Other Disease			
Diabetes				Kidney Disease							

PERSONAL MEDICAL HISTORY:

HAVE YOU HAD?	YES	NO		YES	NO		YES	NO		YES	NO
Scarlet Fever			Recurrent Headache/Migraines			Shortness of Breath			SURGERY:		
Measles			Frequent Colds			Tumor, Cyst or Cancer			Appendix		
German Measles			Head Injury with Unconsciousness			Liver Disease			Tonsils		
Mumps			Hay Fever			Stomach or Intestinal Problem			Hernia		
Chicken Pox			Asthma			Gallbladder Trouble			Other:		
Malaria			Tuberculosis or Positive Skin Test			Recurrent Diarrhea			ALLERGY - TO ANY OF THE FOLLOWING?		
Gum/Tooth Trouble			Chest Pain			Hernia			Penicillin		
Sinusitis			Chronic Cough			Recent Gain/Loss of Weight			Sulfa drugs		
Eye Problems			Palpitations (Heart)			Dizziness or Fainting			Foods		
Ear, Nose, Throat Trouble			High Blood Pressure			Weakness or Paralysis			Other:		
Epilepsy/Seizures			Rheumatic Fever			Venereal Disease			FEMALES ONLY		
Difficulty Sleeping			Heart Murmur			Protein/Sugar in Urine			Severe Cramps		
Frequent Anxiety			Joint Disease or Injury			Frequent Urination			Irregular Periods		
Frequent Depression			"Trick" Knee or Shoulder			Diabetes			Excessive Flow		
Worry/Nervousness			Back Problems			Anemia					
Thyroid Disorder						Mononucleosis					

Have you ever been hospitalized? Yes No

Are you currently on any medications? Yes No

Do you have any chronic illnesses? Yes No

If you answered yes to any of the above questions (including Personal Medical History), please explain:

PLEASE MAIL COMPLETED FORM TO HEALTH SERVICES IN THE ENCLOSED ENVELOPE BY: AUGUST 1 FOR FALL SEMESTER JANUARY 2 FOR SPRING SEMESTER



HEALTH SERVICES
 60 WEST OLSEN ROAD #4300
 THOUSAND OAKS, CA
 91360-2700
 T: (805) 493-3225
 F: (805) 493-3955

WWW.CALLUTHERAN.EDU/HEALTH

HEALTH INSURANCE INFORMATION

Health Insurance Co. _____ Policy# _____

Street Address _____ Telephone (_____) _____

City _____ State _____ Zip/Postal Code _____

Is this insurance: HMO PPO Other _____

CLU Health Services recommends that you check with your health insurance company to verify coverage in the Thousand Oaks, California area. If the insurance is an HMO consider changing the student's Primary Care Physician to a local physician while classes are in session.

MEDICAL/SURGICAL AUTHORIZATION

I am aware that I may access CLU Health Services' Privacy Policy online at www.callutheran.edu/Health or request a copy at the Health Services Office. In case of illness or injury, consent is given to the University for examination and treatment of the named student either at CLU Health Services or by outside medical facilities as needed. Consent is further given for admission to a hospital for necessary medical or surgical treatments as ordered by a healthcare provider. It is agreed that all medical and/or hospital expenses incurred beyond those covered by any applicable insurance policy, including the student insurance policy, will be paid directly and promptly by the undersigned student and parents or guardians, and the University will not be responsible thereon.

Student Signature Date Age

Parent/Guardian Signature (if student under age 18) Date

MEDICAL RECORDS RELEASE

I authorize the release of information to and from other treating medical providers. I also authorize the release of medical information as requested by insurance companies for billing purposes only. (While CLU Health Services does not bill insurance for services provided by our office, insurance companies still need our records to assist them in their billing process for medical treatment outside CLU Health Services.)

Student Signature Date Age

Parent/Guardian Signature (if student under age 18) Date

Parent Name (print)

ATTENTION ALL ATHLETES

Are you considering trying out for an intercollegiate sport(s) while at CLU? Yes No

If so, which sport(s)? _____

Indicating the above does not commit you to any team or sport. If you are interested in participating on an intercollegiate athletic team (including cheerleading), contact the Athletic Department for further information and forms. Also, see www.dusports.com



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