SNU HEALTH HISTORY FORM

Name: _____

Date of Birth: _____/_____/_____ Country of Citizenship: _____

Address: _____

Number and Street City State ZIP

Telephone: (_____) _____ Sex: F M Marital Status: _____

Parent(s) Name:_____ Parent(s) Phone: cell (_____)_____ Work (_____)_____
Medical Insurance Company _____ Insured's Name
_____

If previously attended SNU please give the semester and year of last attendance:_____

Enrolling:_____ Year Spring / Fall

MEDICAL HISTORY Have you been treated for:

	YES	NO		YES	NO		YES	NO		YES	NO
ADD/ADHD			Eating Disorder			MRSA			**Allergy:**		
Anemia			Eye Disorder			Pain/Pressure in Chest			Aspirin		
Anxiety			Head Injury			Peptic Ulcer			Codeine		
Arthritis			Hearing Difficulty			Recent Weight Change			Penicillin		
Asthma			Heart Disorder			Seizure Disorder			Sulfa		
Back Injury			Hepatitis			Shortness of Breath			Latex		
Bleeding Disorder			Hernia			Sinusitis			Wasp/Bee Stings		
Bone or Joint Disease			High Blood Pressure			Tuberculosis			Foods (specify)		
Cancer			Irritable Bowel Syndrome			Bipolar disorder			Other Allergies:		
Chicken Pox			Infectious Mononucleosis			Substance abuse			**Surgery:**		
Depression			Irregular Sleep Patterns			Personality disorder			Appendectomy		
Diabetes			Kidney/Bladder Disease						Tonsillectomy		
Dizziness, Fainting			Migraine Headaches						Hernia Repair		
Ear, Nose, Throat Disorder			Menstrual Disorder						Other Surgeries:		

Other condition(s) not listed:
_____
_____

Give details of positive (Yes) answers:
_____
_____
_____

Have you received treatment or counseling for **mental healthcare**? Yes No If "Yes", please explain:
_____

Current Medications (*Please List ALL MEDS*) _____ _____
_____ _____

_____ _____ _____

FOR ALL STUDENTS UNDER 18 YEARS OF AGE: I authorize the Southern Nazarene University Student Health Center to administer medical and surgical services, immunizations, and therapeutic procedures as deemed necessary by duly licensed personnel.

_____***(Parent's or Guardian's Signature) (Date)*** _____

FOR ALL STUDENTS: By signature, I verify that the information provided on this form is true and I give permission for such diagnostic, therapeutic, and operative procedures as may be deemed necessary for me.

_____***(Student's Signature) (Date)*** _____