

MEDICAL HISTORY FORM

Berea College Health Service
CPO 2174 Berea, KY 40404
Phone (859)985-3212 Fax (859)985-3910

Name: _____
Last First M. I.

Address: _____
Street City State Zip

Date of Birth: ____/____/____ Social Security # ____/____/____ Phone(____)____
Mo Dy Yr

Sex: ____Male ____Female Status: ____M ____S ____W ____D Beginning Term: _____

Relative or guardian to be notified in case of emergency:

Name: _____ Phone(____)_____

Address: _____
Street City State Zip

Family Physician: _____ Phone(____)_____

Address: _____
Street City State Zip

Health Insurance Information (Please include a copy of both sides of your insurance card)

___ NONE (All Berea College students are required to have health insurance coverage. Those without coverage will be assessed a nominal health insurance fee each semester).

Company Name _____ Phone(____)_____

Billing Address _____
Street City State Zip

Policy Holder _____ Relation to Student _____

Coverage to age _____ Policy Number _____ Group Number _____

PERSONAL HEALTH HISTORY (Please attach an extra sheet of paper if necessary to fully answer the following questions)

1. List any current medical problems.
2. List any past medical problems.
3. Have you had chickenpox? ____yes ____no
4. List any operations you have had, and the year for each one.
5. List any other hospitalizations and dates.
6. List any injuries or accidents and dates.
7. Do you take any medications? ___Yes ___No If yes, list any current medications, including non prescription medications, birth control pills, vitamins and supplements, include name, strength and dosage.
8. Are you allergic to any medications? ____yes ____no Please specify.
9. Are you taking allergy shots? ____yes ____no
10. Have there been any recent changes or crises in your own life or in your family? ____yes ____no Please describe
11. Do you have any physical conditions or disabilities that may require special accommodations or arrangements? ____yes ____no. If you have checked Yes, please explain.

Family History				If Living		If Deceased	
	Name			Age	Health	Age at Death	Cause
Father							
Mother							
Brother(s)/Sister(s)* (check box)		M	F				
Husband/Wife							
Son(s)/Daughter(s) (Check box)							

***Since some names may be used for either men or women, please check the sex for each sibling or child.**

Do you or any of your blood relatives have or have had any of the following diseases? Please place a check beside the disease and tell which relative: father (F), mother (M), sister (S), brother (B), grandfather (GF), grandmother (GM), or self.

√	Relative	Type	√	Relative	Type
		High Blood Pressure			Bleeding Tendency
		Cancer			Stomach Ulcers
		Stroke			Kidney Disease
		Diabetes			Goiter
		Leukemia			Arthritis
		TB			Colitis
		Epilepsy			Rheumatic Heart Disease
		Heart Attack			Mental Problems
		Migraines			Gout
		Asthma			

I certify that the above information is complete and accurate to the best of my knowledge.

Date: _____ / _____ / _____ Signature of applicant: _____
Mo Dy Yr

Students who will be under 18 years of age at the time of entrance to Berea College **MUST** have the following signed by a parent or legal guardian and this signature witnessed by one persons NOT related to signer or applicant. This form, properly complete, is a prerequisite to registration for classes.

I GIVE MY CONSENT FOR MY SON/DAUGHTER/OR WARD TO BE TREATED IN MY ABSENCE AT BERA COLLEGE HEALTH SERVICE. IN ADDITION, IF MY SON/DAUGHTER/OR WARD SHOULD BECOME SUDDENLY ILL AND BE FOUND BY THE ATTENDING PROVIDER TO NEED EMERGENCY SURGICAL OR MEDICAL CARE, AND IF ATTEMPTS TO REACH ME TO GET MY PERMISSION FOR SUCH CARE HAVE FAILED, I HEREBY GIVE PERMISSION TO THE PROVIDERS CONCERNED TO GIVE SUCH EMERGENCY CARE UNTIL I CAN BE REACHED.

Witness (not a relative) Signature of parent or guardian

Date _____ / _____ / _____
Mo Dy Yr