BLUFFTON UNIVERSITY HEALTH CENTER
Marbeck Center 70
1 University Drive
Bluffton, OH 45817-2104

BLUFFTON UNIVERSITY MEDICAL HISTORY FORM

***EACH STUDENT ON CAMPUS* must complete this form. Please print in ink.**

Name:_____ Birthdate: _____/_____/_____
Last First Middle

Social Security #: _____ Sex: M _____ or F _____

Home Address: _____
Street City or Town State Zip Code

Telephone: (_____) _____ E-mail address: _____

Marital Status: Single____ Married_____ Divorced_____

Entering Bluffton University as: First Year_____ Sophomore_____ Junior_____ Senior_____

Major: _____

Parent(s) / Guardian / Spouse name: _____
P / G / Sp
(circle) _____
Street City or Town State Zip Code

Home Phone Number (____)_____ Work Phone Number: (_____)_____

Person to contact in case of EMERGENCY-other than person(s) above:

Name: _____ Relationship: _____

Address: _____
Street City or Town State Zip Code

Home Phone Number (____)_____ Work Phone Number: (_____)_____

Previous medical care provider:

Name: _____ Title:_____

Telephone:(_____)_____

Address: _____
Street City or Town State Zip Code

Last time attended by this or another physician: _____/_____/_____

Name: _____

LIST - Medication Allergies

_____

_____

PERSONAL HEALTH HISTORY

Check at right of each item. All items require a "Yes" or "No" response.
If "Yes", explain as appropriate. *(Use back of sheet if necessary.)*

	Yes	No		Yes	No
PAST ILLNESSES:			***HAVE YOU EVER HAD:***		
Hospitalization (date, reason)			Migraines (diagnosed by M.D.)		
Operation (date, type)			Epilepsy/convulsion		
Serious accident			Paralysis or disability		
Serious Illness			Thyroid problems		
Emotional problem			High blood pressure		
Other significant health problems (specify)			Rheumatic fever		
			Heart murmur (diagnosed by MD)		
COMMUNICABLE DISEASES - GIVE DATE			Mitral valve prolapse		
Chicken pox			Asthma		
Malaria			Colitis/ileitis		
Tuberculosis			Irritable bowel		
Other (specify)			Hepatitis		
			Kidney Disease		
			Cancer		
ALLERGIES:			Back problems		
Seasonal			Anorexia/Bulimia/Eating Disorder		
animals			High cholesterol		
foods			Sexually transmitted disease		
Life threatening reaction to insect bites, etc.			Diabetes		
Do you carry epinephrine kit?			Recurrent infections		
Latex					
			CURRENT HEALTH PROBLEMS:		
			Are you currently in psychiatric counseling?		
LIFESTYLE:			Do you have a chronic disease? Identify:		
Alcohol (drinks per week)			Physical disability (type)		
Cigarettes per day years smoking			Learning disability		
Do you diet frequently?			Visual impairment (describe)		
Do you exercise regularly?			Hearing aid		
Do you wear a seatbelt?			Crutches, braces or prosthesis		
Special diet restriction? (specify)			Loss of paired organ (i.e., one eye, one kidney, etc.)		
			Are you presently under treatment for any medical problems? (specify)		

CURRENT MEDICATIONS (please add page as needed):

Name of Medication	Reason for Use

FAMILY HISTORY

Among your blood relatives (include parents, brothers, sisters, grandparents, aunts, uncles) is there any history of, or present illness of any of the following:

ILLNESS	YES	NO	RELATIONSHIP
Alcoholism			
Asthma			
Bleeding Disorder			
Cancer			
Diabetes			
Emotional Disorder			
Epilepsy/Convulsions			
Heart Attack before 60			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Stroke			
Tuberculosis			
Other Significant Problems			

This document is used for evaluating the physical and emotional condition of each student so that the Health Service can meet the student's needs. **THIS IS A CONFIDENTIAL COMMUNICATION** between the student and the Health Service. This information will not be shared with anyone without the written consent of the student.

To the best of my knowledge, the information submitted is complete and accurate.

_____ _____

Student's Signature Date

CONSENT FOR TREATMENT *(Required for students under 18)*

I give consent for my minor child, _____, to receive routine care from the Bluffton University Health Service, its nurses, and its physicians.

_____ _____ ____/____/____

Signature of Parent/Guardian Print name of Parent/Guardian Date

RETURN THIS FORM *ONLY* TO:

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1 University Drive
Bluffton, OH 45817-2104