NORTHWEST NAZARENE UNIVERSITY
Health Questionnaire and Medical History

This very confidential information will be sent directly to our Health Center. No one will have access to it except the college nurse, your physician and the Director of Counseling in Student Development.

INFORMATION

Term Applied:_____ Date:_____ Sex: ___Male ___Female

Name:_____ Marital Status: ___Single ___Married ___Divorced ___Widow
Last First Middle

Social Security #:_____ Date of Birth:_____ Present Height:_____ Present Weight:_____

Address:_____
Street/Apt.# City State Zip

IN CASE OF EMERGENCY CONTACT:

Name:_____ Phone # (_____)_____

Relationship: Parent Guardian Spouse Other:_____

INSURANCE:

Health Insurance Company:_____ Policy #_____

Name of Responsible Person:_____

Social Security # of Responsible Person:_____ Birthdate of Responsible Person:_____

Are you now under treatment for present illness, injury or problem? Yes No

If yes, explain and/or send physician's statement.

_____

_____

PHYSICAL EDUCATION:

Please check the appropriate statement: _____ Physically able to take P.E.
_____ Should be excused from some activity
_____ Should be excused from all activity

Nature of problem to be excused. **This must be verified by family physician.**_____

_____

_____

MMR VACCINE STATEMENT:

It is a **STATE/ADMISSION REQUIREMENT** of all entering students to submit proof or copy of the following:

PLEASE CHECK ONE:

1. _____Verification of administration of MMR (Mumps/Measles/Rubella) vaccine: _____ _____ _____
DAY MONTH YEAR

Physician's signature:_____

2. _____Copy of Immunization Records (Contact your public school or private physician).

3 _____Birthdate of 1957 or before (If born before 1957, vaccine not necessary).

If you are unable to obtain the above documentation, **it will be necessary for you to receive an MMR vaccine** from a private physician or local health center, **before you may complete the Admission process. STATEMENT OF INCIDENCE OF HAVING THE DISEASE(S) IS NOT ADEQUATE DUE TO DIFFICULTY OF DIAGNOSIS.** Please submit copy of blood test/lab work if having the disease made it unnecessary to receive the vaccine.

If opposed to immunizations due to religious or medical reasons, please attach documentation to that effect to this Health Questionnaire.

LAST TETNUS IMMUNIZATION:_____ POLIO IMMUNIZATION_____
DAY MONTH YEAR DAY MONTH YEAR

Student's Signature:_____ Date:_____

FAMILY HISTORY

	Age	Condition of health *(If deceased, list cause)*
Father		
Mother		
Brothers/Sisters		
Spouse / Children		

Has any member of your family, including Grandparents had any of the following? Please mark with:
"**F**" - Father, "**M**" - Mother, "**G**" - Grandparent.

_____Allergies	_____Glaucoma
_____Arthritis	_____Heart Problems
_____Asthma	_____High Blood Pressure
_____Cancer	_____Epilepsy
_____Diabetes	_____Urinary problems
_____Depression	_____Anxiety
Ulcer/stomach problems	

YOUR HEALTH HISTORY

PLEASE MARK ANY OF THE FOLLOWING YOU NOW HAVE OR EVER HAVE HAD.

__Dizziness	__Hearing loss	__German Measles	__Painful Urination	__Sore Throats	__Anorexia	__Acne	__Alcoholism
__Joint Pain	__Scarlet Fever	__Rheumatic Fever	__Mononucleosis	__Measles	__Hernia	__Earaches	__Bulimia
__Drug Addiction	__Mumps	__Chicken Pox	__Bladder Infection	__Eye Problems	__Pneumonia	__Night Sweats	
__Polio	__Rectal Bleeding	__Venereal Disease	__Crying Spells	__Hemorrhoids	__Asthma	__Colds	__Fainting
__Sexually Transmitted Diseases (STD's)			__AIDS	__Depression	__Insomnia	__Anxiety problems	
__Nervous Exhaustion		__Yellow Jaundice	__Allergies	__Indigestion			

Have you been hospitalized for any serious illness, accident, or surgery? Write in your most recent hospitalizations and include the following information:

Date	Operation or Illness	Hospital	City & State

Have you ever been involved in personal counseling in the last five years? __Yes __No If yes, please give reason:
_____
_____

Do you smoke? __Yes __No # of packs____ # of years____ Chew Tobacco? __Yes __No
Do you drink alcohol? __Yes __No How often?_____
Have you ever used psychedelic or addictive drugs with or without prescription? ___Yes ___No
When?_____
Drug Name:_____ Length of Time:_____
Reason:_____

1. List all allergies and reactions:
_____
_____
_____

2. List all medications you are currently taking and dosage prescribed by physicians:
_____
_____
_____

TESTS YOU HAVE HAD

__ Ultrasound	__ EKG	__ Upper GI	__ ECG	__ Lower GI
__ X-rays	__ AIDS Blood Test		__ Other Blood Tests	

__ Other:_____

Please give date(s) of test(s) and reason for testing:_____
_____