Medical History

The following health history is confidential and does not affect your admission status. This information is requested to determine if you have any medical conditions that may require special assistance from the school. This information will be used to help us provide continuity of care for you. This information will not be released without your written permission except in an emergency situation, by court order or by parental consent if under age 18. Please attach additional sheets for any items that require additional explanation.

SECTION 1: REPORT OF MEDICAL HISTORY (Please print in black ink)

LAST NAME FIRST NAME **MIDDLE NAME** **STUDENT ID NUMBER** **SOC. SECURITY NUMBER**

PERMANENT ADDRESS **CITY** **STATE** **ZIP CODE** **AREA CODE/PHONE**

DATE OF BIRTH (mo/day/yr) _____ **PLACE OF BIRTH** _____ **GENDER** ☐M ☐F

EMAIL	CLASS YOU ARE ENTERING (circle) FR. SO. JR. SR. GRAD. PROF.	SEMESTER ENTERING (circle): FALL SPRING SUMMER 1 SUMMER 2 YEAR

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY **RELATIONSHIP**

ADDRESS **CITY** **STATE** **ZIP CODE** **AREA CODE/PHONE**

NAME AND ADDRESS OF HEALTH INSURANCE CO._____ AREA **CODE/PHONE**_____

NAME OF POLICY HOLDER _____ **POLICY/CERTIFICATE #** _____ **GROUP #**_____

SECTION 2: FAMILY MEDICAL HISTORY (Please print in black ink)

HAS ANY PERSON, RELATED BY BLOOD, HAD ANY OF THE FOLLOWING CONDITIONS:

	Yes	No	Relationship		Yes	No	Relationship		Yes	No	Relationship
High blood pressure				Cholesterol or blood fat Disorder				Cancer (type):			
Stroke				Diabetes				Alcohol/drug problem			
Heart attack before age 55				Glaucoma				Psychiatric illness			
Blood or clotting disorder				Asthma							

SECTION 3: PERSONAL MEDICAL HISTORY (Please print in black ink)

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING: PLEASE ANSWER EACH QUESTION AND INDICATE YEAR FOR YES ANSWERS

	Yes	No	Year		Yes	No	Year		Yes	No	Year		Yes	No	Year
Anemia or Sickle cell anemia				Chest Pain or pressure				Headaches (Frequent/severe)				Protein or blood in urine			
Anorexia/Bulimia				Chronic cough				Head injury (severe)				Chronic pain (severe/recurrent)			
Allergies/Hay fever				Concussion				Hepatitis or Jaundice				Pneumonia			
Asthma				Cancer or Tumor				Hearing loss				Rectal disease			
Arthritis								Hernia (specify)				Rheumatic or Scarlet fever			
				Diabetes				Intestinal problems				Serious skin disease			
Breathing problems/				Dizziness or fainting				Kidney stone				Seizures			
Back or neck injury				Depression or Excessive worry				Learning disorder (specify)							
Bone, joint or other deformity				Eye problem (not glasses)				Malaria				Thyroid trouble			
Broken bone(specify)				Easy fatigability								Tuberculosis			
Bladder or kidney Infection				High blood pressure				Menstrual cramps (severe)							
Blood transfusion				Heart condition				Physical disability				Other (specify)			

Please complete reverse side.

SECTION 3: PERSONAL MEDICAL HISTORY – CONTINUED (Please print in black ink)

Describe any conditions or disabilities that would exclude participation in physical education (e.g., swimming). _____

Do you exercise three or more times per week? ☐ YES ☐ NO Do you use a seatbelt on a regular basis? ☐ YES ☐ NO

Please list any drugs, medicines, birth control pills, vitamins, minerals (prescription and nonprescription or herbal medicines) you use and indicate how often you use them?

Name of drug	Reason for taking drug?	How much are you taking and how often?
1.		
2.		
3.		
4.		

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation (specify when, where and why)
Have you ever been a patient in any type of hospital?			
Has your academic career been interrupted due to physical or emotional problems?			
Have you ever had any serious illness or injuries other than those already noted?			

IMPORTANT INFORMATION.....PLEASE READ AND COMPLETE

STATEMENT BY STUDENT:

(A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, except in an emergency or by Court Order. However, if I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission for the Student Health Center to release information from my record to a physician, hospital or other medical agency involved in providing me with emergency treatment and/ or medical care.

(B) I hereby authorize any medical treatment for myself that may be advised or recommended by the providers of the Student Health Center.

(C) Mental Health: I also hereby authorize transportation to Howard University Hospital when recommended by the psychologist/psychiatrist of the University Counseling Center.

_____ _____

Signature of Student **Date**

PARENTAL/GUARDIAN PERMIT – MUST BE COMPLETED IF STUDENT IS UNDER 18 YEARS OF AGE

The LAW requires that parental permission be obtained for medical treatment of minors. A parent or guardian should sign the following consent form so that medical treatment may be given to the student who is a minor. However, no major operation will be performed except in extreme emergency, without parent/guardian being contacted and fully informed.

I give permission for such diagnostic and therapeutic procedures as may be deemed necessary for my daughter/son/ward.

(Signed)_____ (Relationship) _____ (Date) _____