

# PERSONAL HEALTH HISTORY

**UNION**  
COLLEGE

3800 South 48th Street  
Lincoln, NE 68506-4386

800.228.4600

www.ucollege.edu

Date \_\_\_\_\_ SS# \_\_\_\_\_

Name \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Last/Family First Middle

Home Address \_\_\_\_\_

Birthplace \_\_\_\_\_ Birthdate \_\_\_\_\_  
Month Day Year

Marital Status:  Married  Single  Divorced  Widowed Sex:  Male  Female

Age \_\_\_\_\_ Height \_\_\_\_\_ Feet \_\_\_\_\_ Inches Weight \_\_\_\_\_ Lbs.

Have you attended another college?  Yes  No

Parent's or Guardian's Name \_\_\_\_\_ Telephone \_\_\_\_\_

Parent's Mailing Address \_\_\_\_\_

## SECTION A. IMMUNIZATION RECORD

Required Immunizations: Have your immunization completed before registration.  
Please attach documentation for the following:

	Date	Booster
	mm / dd / yy	— / — / —
1. Tetanus (Td) or (Tdap) within 10 years	— / — / —	— / — / —
2. Measles, Mumps, Rubella (MMR) —two shots required after first birthday	— / — / —	— / — / —
3. Polio Series	— / — / — — / — / —	— / — / — — / — / —
4. TB Skin Test (TST) within one year, if positive, chest X-ray within one year	— / — / — — / — / —	Results: — Results: —
5. Hepatitis B Series	— / — / —	— / — / —
6. Meningococcal Vaccine	— / — / —	

You are on "Hold" until the following Union Student Health Requirements are met:

- o Documented proof of current Tetanus immunization within the past ten (10) years.
- o Documented proof of immunity to Red Measles (Rubeola)  
Each student born after 12/31/56 must show proof of two (2) Red Measles (Rubeola) vaccines after their first birthday,  
or a blood test (titre) proving their immunity to the disease.
- o Documented proof of immunity to German Measles (Rubella)  
Each student born after 12/31/56 must show proof of having German Measles (Rubella) vaccine after their first birthday,  
or a blood test (titre) proving their immunity to the disease.
- o Documented proof of current negative TB (Tuberculosis) skin test (TST) within one (1) year prior to admission. If the TB  
skin test is positive, you must show proof of having a normal chest X-ray within one (1) year prior to admission.

**SECTION B. HEALTH HISTORY**

**A) Ear, Nose & Throat**

Do you presently have or have you had

- 1. Trouble with hearing?
- 2. Severe difficulty breathing through your nose?
- 3. Frequent sore throats or colds?

**B) Eyes**

Do you presently have or have you had

- 1. Need of eye glasses or contact lenses?
- 2. Loss of vision or damaged function of one or both eyes? Describe \_\_\_\_\_

**C) Dental**

Do you presently have or have you had

- 1. Gum or tooth trouble?

**D) Respiratory**

Do you presently have or have you had

- 1. Loss of or damaged functioning of a lung?
- 2. Asthma?
- 3. Pneumonia?
- 4. Tuberculosis?

**E) Cardiovascular**

Do you presently have or have you had

- 1. A heart murmur that the doctor said is serious?
- 2. High blood pressure?
- 3. Rheumatic fever?

**F) Gastrointestinal**

Do you presently have or have you had

- 1. Consistent pain in the abdomen?
- 2. Frequent episodes of vomiting?
- 3. Trouble with gas, heartburn, sour stomach, bloating, or indigestion?
- 4. Stomach or duodenal ulcers?
- 5. Recurrent diarrhea?
- 6. Jaundice or hepatitis?
- 7. Any serious or disabling stomach or bowel problems? If yes, specify \_\_\_\_\_

**G) Genito-Urinary**

Do you presently have or have you had

- 1. Damaged function of a kidney?
- 2. Frequent infections in the kidney or bladder?
- 3. A sexually transmitted disease or infection?
- 4. Frequent urination?

Females only

- 5. Irregular periods?
- 6. Severe cramps?
- 7. Excessive flow?
- 8. Any medicine for menstrual problems?  
If yes, please specify \_\_\_\_\_

**H) Endocrine**

Do you presently have or have you had

- 1. An over-active thyroid?
- 2. An under-active thyroid?
- 3. Diabetes?

Recent  
(at present or  
within past year)  
YES NO

Past  
(More than  
one year ago)  
YES NO

	Recent (at present or within past year)		Past (More than one year ago)	
	YES	NO	YES	NO
<b>I) Neurology</b>				
Do you presently have or have you had				
1. A nervous breakdown?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Hospitalized for problems with your nerves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Seizures in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Recurring severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Blackout spells (or episodes of confusion)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>J) Musculo-Skeletal</b>				
Do you presently have or have you had				
1. Back stiffness or pain which interferes with your normal activity for more than 7 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Troublesome joint stiffness, pain or swelling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Rheumatoid arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. An amputation of an arm or leg?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>K) Skin</b>				
Do you presently have or have you had				
1. Troublesome acne?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Persistent or recurrent skin rash?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Mole(s) that changed in size or color?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>L) Hematology-Blood</b>				
Do you presently have or have you had				
1. Serious blood reaction to a drug treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Anemia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Excessive bruising?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>M) Emotional</b>				
1. Do you feel lonely or depressed most of the time?			<input type="checkbox"/>	<input type="checkbox"/>
2. Would you say that your stress level is very high?			<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever seriously contemplated or attempted suicide?			<input type="checkbox"/>	<input type="checkbox"/>
4. Have you obtained help from a mental health professional?			<input type="checkbox"/>	<input type="checkbox"/>
5. Do you feel hopeless?			<input type="checkbox"/>	<input type="checkbox"/>
6. Are you in considerable emotional pain?			<input type="checkbox"/>	<input type="checkbox"/>
7. Do you feel that you need to do something to change things in your life?			<input type="checkbox"/>	<input type="checkbox"/>
8. Do you feel bad about yourself most of the time?			<input type="checkbox"/>	<input type="checkbox"/>
9. Would you find counselling useful for any of your problems?			<input type="checkbox"/>	<input type="checkbox"/>

When significant emotional problems are evident, the admissions committee will be informed. Records and advice may be needed from your previous health care providers.

**N) General Medical**

1. Do you take any medication or injections, prescribed or over the counter, or medicinal herbs?  YES  NO  
 If yes, list the names of all medications and shots prescribed and non-prescribed which you are taking regularly \_\_\_\_\_

For any prescription medicine (shots) which you wish the Health Service to administer to you, you must bring a written order signed by your physician. This order must name the medicine and must include the amount to be given, the frequency and method of administration, and how long this medication is to be continued.

2. Have you ever been admitted to a hospital as an in-patient?  YES  NO

3. Have you had surgery?  YES  NO  
 If yes, list all operations and the year of each \_\_\_\_\_

4. Have you had serious injuries?  YES  NO  
 If yes, list injury (injuries) and year of each. \_\_\_\_\_

5. Has a physician told you that you should have an operation that you still need?  YES  NO

6. Are you sensitive to any drugs? If yes, please specify \_\_\_\_\_  YES  NO

7. Other allergies? \_\_\_\_\_  YES  NO

**O) Childhood Diseases**

Have you had	YES	NO
1. Chickenpox?	mm/yy <input type="checkbox"/>	<input type="checkbox"/>
2. Measles (Red)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Measles (German)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Mumps?	<input type="checkbox"/>	<input type="checkbox"/>
5. Scarlet Fever?	<input type="checkbox"/>	<input type="checkbox"/>
6. Other? _____		

**P) General Profile**

1. Do you feel that your current state of health is interfering with your normal activity? \_\_\_\_\_  YES  NO
2. Have you in the past been under a physician's care for other than minor illnesses?  YES  NO  
If yes, please describe \_\_\_\_\_
3. Are you presently under a physician's care for other than minor illnesses?  YES  NO  
If yes, please describe \_\_\_\_\_
4. Must you limit your physical activity?  YES  NO
5. Do you consider yourself to have a physical handicap?  YES  NO  
If yes, please specify \_\_\_\_\_  
What accommodations do you need? \_\_\_\_\_
6. When was your last physical exam? \_\_\_\_\_
7. When was your vision last checked? \_\_\_\_\_
8. When was your last dental check up? \_\_\_\_\_
9. Do you have any health problems which were not mentioned in this questionnaire or additional comments which you would like to add?  YES  NO  
If yes, please specify \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I CERTIFY THAT THE ANSWERS TO THE QUESTIONS ABOVE ARE CORRECT TO THE BEST OF MY KNOWLEDGE. I also understand that the Health Service is an important, integral part of the student services program at Union College. Union College, through its student services, is committed to the traditional Seventh-day Adventist concept of the harmonious development of the physical, the mental, and the spiritual. The Health Service works closely with the residence hall deans, counselors and teachers to help the students realize their full potential. Therefore, the student's medical record is open to the student and members of the student services personnel as necessary, just as are other files of the student personnel services.

Date \_\_\_\_\_ Signed \_\_\_\_\_

**Treatment Authorization must be signed by a parent or guardian if student is under 19**

I hereby authorize and give my consent to the Health authorities of Union College or any licensed practitioner to perform upon or administer to (Name of Student) \_\_\_\_\_ any reasonably necessary medical or surgical treatment. I also give permission to administer whatever anesthetic may be necessary or advisable during the medical or surgical procedures. This authorization is intended to cover emergency treatment, immunizations, injections, and minor operations and procedures.

In the event of indicated major surgery, or major treatment, the College Authorities or physicians are not hereby excused from attempting to contact me before relying upon this authorization. This authorization does not entitle the service or physician to render any medical or surgical treatment without the student's personal consent, unless the student is unable to give consent (i.e. unconsciousness).

In addition, I give authorization for the student to receive mental health counseling services. Permission is also granted to release information from the student's medical record to person or persons designated by the college when, in the opinion of the Director of Student Health Service, release of specific information is deemed necessary. This permission is good only while the student is attending the above college and only until the student has attained his nineteenth birthday.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to student \_\_\_\_\_ Address \_\_\_\_\_

Telephone # \_\_\_\_\_

PLEASE SEE UNION'S CATALOG FOR A DESCRIPTION OF THE STUDENT HEALTH SERVICE.  
A copy of the "Student Accident and Sickness Insurance Plan" will be given to you at registration, if you require insurance provided by the college.