

Heidelberg College
Stoner Health Center
310 E. Market Street
Tiffin, Ohio 44883

Medical History Questionnaire



Fax: (419) 448-2372
Phone: 1-800-925-9250 Ext. 2042

Name _____ Today's Date _____
First Middle Last

Date of Birth _____ Social Security Number ____ - ____ - _____ Sport (s) _____
(if applicable)

Parent(s)/Guardian(s) _____ Home Phone _____
Name

Home Address _____ Parent's Work Phone Number(s) _____

City _____ State _____ Zip Code _____

Person to Contact in Case of Emergency _____
Name Phone Number

Student's Email Address _____

Family Physician _____
Name Address Phone

ALLERGIES _____ CURRENT MEDICATIONS/SUPPLEMENTS _____

Medical/Dental Authorization

(to be signed by parent or guardian if student is under 18 years of age)

I, _____, give Heidelberg College Stoner Health Center medical and nursing permission to administer any medical procedures that are necessary in an emergency, to my Son/Daughter.

Signature of Parent Date Signature of Student Date

Health Insurance

****PLEASE INCLUDE A COPY OF THE HEALTH INSURANCE CARD WITH THIS FORM****

Do you have insurance under a family plan? Y / N Do you plan to have Heidelberg College Student Health Insurance? Y / N

Name of Insurance Company/Plan _____ Identification Number _____

Insurance Company Address _____ Phone # _____

Name of Contract Holder _____

Prescription (Pharmacy) Insurance

****PLEASE INCLUDE A COPY OF THE PRESCRIPTION CARD WITH THIS FORM****

Name of Insurance Company _____ Identification Number _____

Insurance Company Address _____ Phone # _____

Name of Contract Holder _____ Co-Pay \$ _____ (Brand) \$ _____ (Generic)

Pharmacy Preference (please select one)

Rite-Aid / Wal-Mart / The Pharm / Kroger / The Medicine Shoppe / Zellner Pharmacy (has delivery service)

I hereby certify that all information I have provided is true and correct to the best of my knowledge. I also approve the exchange of this information between my family physician, referring physician, the athletic training department, residence life staff and Mercy Hospital of Tiffin, Ohio and the staff of Stoner Health Center, if necessary.

STUDENT / PARENT SIGNATURES

DATE

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If you have ever had or presently have any of the following, please check the appropriate area with age noted.

Infectious Disease	Yes/Age	Neurological	Yes/Age	Gastro-Intestinal	Yes/Age
Tuberculosis		Headaches/Migraines		Ulcer	
Mononucleosis		Dizziness		Ulcerative Colitis	
Eyes, Ears, Nose		Epilepsy		Hepatitis/Liver Disease	
Blurred Vision		Head Injury/Concussion		Genital-Urinary	
Glasses/Contacts		Psychiatric		Bladder Disease	
Hay Fever		Heart & Lungs		Kidney Disease	
Hematologic		Heart Murmur		Kidney Stone	
Anemia		High Blood Pressure		Musculoskeletal	
Blood Disorder		Shortness of Breath		Bone Fracture	Area:
Metabolic		Asthma		Back Problem	
Diabetes		Palpitations		Joint Deformity	Area:
Thyroid Problem		Tuberculosis		Hernia	
Hypoglycemia		Exercise Induced Asthma		Knee Problem	Area:
Females Only		Males Only		Other	
Menstruation		Prostate Gland Disorder		"Stingers"/"Burners"	
Painful		Testicular Disease/Disorder		Heat-Related Illness	
Irregular				Extreme Wt. Loss/Gain	
Duration		Vision Exam in last 2 yrs.	Yes/No	Eating Disorder	
		Chicken Pox (Yes/No) Age		Depression	
				Smoking/Alcohol Use	

If YES to any of the above, please explain on the reverse side of this form.

Immunization Record

(**) Please note that the following vaccinations are required for all students admitted to Heidelberg College:

**M.M.R. (Measles, Mumps, Rubella) (Two doses required after 12 months of age)	Dose 1 given at age <u>12-15 months or later</u> _____ M D Y	Dose 2 given at age 4-6 years or later. _____ M D Y				
**TETANUS-DIPHTHERIA (Primary series with DTaP or DTP and booster with Td in the last ten years meets requirement.)	Primary series of four doses #1 _____ M D Y	DtaP/DTP #2 _____ M D Y	DTaP/DTP #3 _____ M D Y	DTaP/DTP #4 _____ M D Y	Td Booster* _____/_____/_____ M D Y	
**POLIO (Primary series in childhood meets requirement; three primary series schedules are acceptable.)	OPV #1 _____ M D Y	OPV #2 _____ M D Y	OPV #3 _____ M D Y	OPV #4 _____ M D Y		
**CHICKEN POX <small>History: chicken pox./varicella, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 years meets the requirement.)</small>	History of Disease Yes or No	Positive Antibody Titer Y or N _____ M D Y	Date of Vaccine #1 _____ M D Y	Date of Vaccine #2 _____ M D Y		
HEPATITIS B Three doses of vaccine (Highly Recommended)	#1 _____ M D Y	#2 _____ M D Y	#3 _____ M D Y			
MENINGOCOCCAL MENINGITIS A, C, Y, W-135 (Highly Recommended) One dose-preferably at entry into college for freshmen living in dormitories or residence halls who wish to reduce their risk of meningococcal disease.	Menactra or Menomune vaccine _____ M D Y					
INFLUENZA (Annual immunization recommended)	_____/_____ M Y	_____/_____ M Y	_____/_____ M Y	_____/_____ M Y		
**TUBERCULOSIS (Mantoux) SCREENING (Required within last 6 months, regardless of prior BCG.) (*If positive, Chest X-Ray is required)	Date Given: _____/_____/_____ M D Y	Date Read: _____/_____/_____ M D Y Result _____mm	Chest X-Ray (attach copy of report)	BCG _____/_____/_____ M D Y		

