NEBRASKA WESLEYAN UNIVERSITY

Student Health Services
Confidential Medical History Report

Name _____
Please print neatly

Social Security Number XXX-XX-_____ **Date of Birth** ____/____/____ **Age** _____ **Sex** _____

Student Cell # _____ **Athlete Y/N** **Transfer Y/N** **Current College Year** **1 2 3 4 5**

Parent 1 Address _____
(street or box) (city) (state) (zip)

Phones: Home _____ **Work** _____ **Cell** _____

Parent 2 Address _____
(street or box) (city) (state) (zip)

Phones: Home _____ **Work** _____ **Cell** _____

Health Insurance Company Name _____ **Health Insurance Policy #** _____
(optional) (attach photocopy of insurance card)

PART I

FAMILY HISTORY

Name/Occupation	Age *(if living)*	Age/Year of Death	Significant Illnesses or Cause of Death
Parent 1 _____			
Parent 2 _____			
Siblings _____			
Spouse _____			
Children _____			

Are there any familial, hereditary or prevalent diseases in your family? (e.g. alcoholism, allergies, cancer, high blood pressure, kidney disease, stroke.) List diseases and relationship of those family members. _____

SELF REPORTED PERSONAL HISTORY

Have you had....?	Yes*	No
Acute infectious diseases		
Chicken Pox		
Hepatitis		
Infectious Mononucleosis (mono)		
Pneumonia		
Tonsillitis		
Typhoid		
Meningitis		
Other		
OTHER DISEASES		
Alcoholism/drug addiction		
Anemia		
Anorexia/Bulimia		
Asthma		
Cancer		
Chronic Bronchitis		
Skin disease (e.g. eczema, psoriasis, ringworm, staph)		
Convulsions, seizures (epilepsy, narcolepsy		
Dental problems		
Diabetes		
G.I. Disease (e.g. GERD, Hiatal hernia, colitis)		
Hay fever/Allergies		
Heart disease (Rheumatic fever, murmur)		
High blood pressure		
Kidney or bladder disease—Urinary Tract Infection		
Other		

	Yes*	No
Orthopedic problem (e.g. knee, back, shoulder)		
Prolonged depression or anxiety		
Speech, hearing, vision problem		
Severe headache (e.g. migraine)		
Thrombophlebitis DVT or Blood Clots		
Thyroid or Endocrine disturbance		
Tuberculosis, History of		
Sleep disturbance (apnea, walking in sleep)		
OTHER HEALTH CARE HISTORY		
Have you been hospitalized?		
Have you had any surgical operations?		
Are you under medical treatment?		
Do you take any prescribed medicine or injections?(see below)		
Do you have a physical, mental or learning disability?		
Are you under care of State Rehabilitation?		
Have you received psychological care?		
Have you traveled outside the U.S.? Where? When?		
MENSTRUAL HISTORY *(females only)*		
Problems (e.g. cramps, irregular, excessive flow)		
Oral contraceptives		
Female infections		
Pregnancies		
Comment on all yes answers to above questions:		

Height ____ Weight ____ Blood Pressure (Optional) _____

ALLERGIC REACTIONS:
(e.g. penicillin, sulfa, food, immunization, ASA, insect bites/stings):

_____

If not enough room, attach list to this page (e.g.:Meds, surgery, etc.)

PART II
IMMUNIZATIONS

Nebraska Wesleyan University requires **Meningococcal** (meningitis) and **MMR** immunizations **PRIOR TO ENROLLMENT**.

MANDATORY IMMUNIZATION HISTORY				
VACCINE	**MM / DD / YY**	**MM / DD / YY**	**MM / DD / YY**	**MM / DD / YY**
MMR (Measles, Mumps, Rubella) Must be after 12 mo. Both immunization dates are required.				
Meningitis (MCV4)				

OTHER IMMUNIZATION HISTORY				
VACCINE	**MM / DD / YY**	**MM / DD / YY**	**MM / DD / YY**	**MM / DD / YY**
DPT (Diptheria/Pertussis/Tetanus)				
Tetanus Td/Tdap (Booster)				
Polio				
Hepatitis B (HBV)				
Varicella (Chicken Pox)				
Hepatitis A (HAV)				
Other				

PART III
EMERGENCY INSTRUCTIONS

Authorities at Nebraska Wesleyan University make every effort to contact parents or guardians in the case of a medical emergency. Please list your preferred emergency contact.

Emergency contact _____

Relationship_____ **Phone**_____

In an emergency, may authorities at Nebraska Wesleyan University use their judgment in obtaining medical care for you? Please check the appropriate box below.

☐ **Yes**
Permission is hereby given to administer recommended medical treatment, diagnostic studies and immunization.

☐ **No**
If permission to provide emergency care is not granted, what should be done in an emergency situation?

_____

Student's Signature _____ Date_____

Parent's Signature_____ Date_____
(required if student is under 19)

Nebraska Wesleyan University may use information in this form to provide you with medical treatment or services. We are required by law to maintain the confidentiality of information disclosed in counseling, and will not disclose such information to third parties without your written authorization except as may be required or allowed by applicable privacy laws.

NWU Full-Time Students, mail completed form to:
Student Health Services • Nebraska Wesleyan University • 5000 Saint Paul Avenue • Lincoln, Nebraska 68504-2794
402-465-2375 • 402-464-7858 Fax