

This page to be filled out by Student.



Student Health Evaluation Form

Student Health Service available only after receipt of History Record and Physical Examination.

This form is to help Central College serve the student as promptly and correctly as possible should the student require the services of the Health Service or the Counseling Service. Filling out this form as completely and correctly as possible will insure optimum physical and mental health for the student while he/she is at Central. Please complete this report before going to your physician for examination.

Name _____ Birth Date _____
Last First M.

Home Address _____ SEX: F _____ M _____
Number or Street City or Town State Zip

Student Cell Phone Number _____

Emergency Notification _____ Relationship _____

Home Address _____ Home Telephone _____

Business Phone _____ Cell Phone _____

Marital Status: Single _____ Married _____ Citizenship _____ Class you are entering _____

Religious Preference _____ Are you planning to play a varsity sport? _____

Family History	Year of Birth	Occupation	State of Health	If Deceased		Have any of your relatives had any of the following?			
				Cause	Age		Yes	No	Relationship
Father						Cancer			
Mother						Tuberculosis			
Siblings						Diabetes			
(List separately)						Kidney Disease			
						Heart Disease/ <small>Sudden death before age 50</small>			
						Arthritis			
						Stomach Disease			
						Asthma, Hay Fever			
						Epilepsy, Convulsions			
						Substance Abuse			
						Mental Health Disorder			
Current medications (include: Allergy med., vitamins, prescription & non-prescription)						Depression			
						Marfan Syndrome			

PERSONAL HISTORY Please answer all the questions. Comment on all positive answers in the space provided.

A. Have you had?	Yes	No		Yes	No		Yes	No		Yes	No
Scarlet Fever			Insomnia			Pain/Pressure in chest during exercise			Gallbladder Trouble or Gallstones		
Measles			Frequent Anxiety			Chronic Cough			Recurrent Diarrhea		
German Measles			Frequent Depression			Palpitations (Heart) during exercise			Rupture, Hernia		
Mumps			Worry or Nervousness			High/Low Blood Pressure			Recent Gain or Loss of Weight		
Chicken Pox			Recurrent Headaches			Nearly or passed out during or after exercise			Epilepsy, Convulsions		
Malaria			Recurrent Colds			Rheumatic Fever or Heart Murmur			Dizziness, Fainting		
Gum or Tooth Trouble			Head Injury with unconsciousness			Injury: stress fracture; dislocated joints/fractured bone			Weakness, Paralysis		
Sinusitis			Hay Fever, Asthma			Injury: sprain, muscle/ligament tear or tendonitis			Venereal Disease/STD's		
Eye Trouble			Tuberculosis			Back Problems			Albumin/Sugar in urine		
Ear, Nose, Throat Trouble			Shortness of Breath			Tumor, Cancer, Cyst			Frequent Urination		
Sickle Cell Trait or Disease (you or family)			Infectious mononucleosis (mono) in past month			Jaundice			FEMALES ONLY: Irregular Periods		
Surgery			Allergy			Stomach or Intestinal Problems			Severe Cramps		
Appendectomy			Penicillin			Diabetes			Excessive Flow		
Tonsillectomy			Sulfanamides			Family death w/no apparent cause					
Hernia Repair			Serum						Age of 1st menstrual period? _____		
Other:			Foods (Which)						Number of periods in last 12 months? _____		

Comment on any positive answers in the space provided: _____

PART II: PHYSICIAN'S REPORT OF HEALTH EVALUATION

TO THE EXAMINING PHYSICIAN: Please review the students' report and complete this physician's form with comments on all positive answers. Since this student has already been accepted for admission, the information supplied will not affect his or her status and will be used only as background for providing any needed care by the Health Services. It will not be released to anyone without the student's consent.

Name _____ SEX: F _____ M _____
 Last First Middle

BP _____ Height _____ inches Weight _____ lbs. What would you like to weigh? _____

Corrected Vision:

Right 20/ _____ Left 20/ _____ Nutritional Status _____ Restricted diet _____

URINALYSIS

Sugar _____
 Albumin _____
 Micro _____

Do you limit or carefully control what you eat? _____ YES _____ NO

Vegetarian _____ Describe _____

HEMATOCRIT _____ or HEMOGLOBIN _____

Blood type (if available) _____

Are there any abnormalities of the following systems?
 Describe fully. Yes No

Describe fully.	Yes	No
1. Head, Ears, Nose or Throat		
2. Teeth and Gums		
3. Respiratory		
4. Cardiovascular		
5. Gastrointestinal		
6. Hernia		
7. Eyes		
8. Genito Urinary		
9. Musculoskeletal		
10. Metabolic/Endocrine		
11. Neuropsychiatric		
12. Skin		
13. Loss or seriously impaired function of any paired organ		

**IMMUNIZATION
 REQUIRED FOR
 ALL STUDENTS**

	Completed		Date of latest immunization
	Yes	No	
Tetanus within 10 years			
Diphtheria within 10 years			
Polio			
MMR (Measles, Mumps, Rubella)			#1 #2

Tuberculin Skin Test:

Date _____ Read _____ Results _____

IMMUNIZATION RECOMMENDED FOR ALL STUDENTS:

Hepatitis A: _____

Hepatitis B:

Dates: #1 _____ #2 _____ #3 _____

Meningitis: Date _____

Varicella: Date _____

Recommendations for physical activity (P.E., intramurals, swimming): Unlimited _____ Limited (Explain) _____

Do you have any recommendations regarding the care of this student? Yes _____ No _____ If so, what? _____

Is the patient now under treatment for any medical condition? Yes _____ No _____ Diagnosis _____

Is the patient now under treatment for any emotional condition? Yes _____ No _____ Diagnosis _____

Last date eye exam completed? _____ Last date dental exam completed? _____

Physician's Signature _____

Address _____

Last Name Printed _____

Date _____

**Please copy this record for your office use. Return original record to:
 Admission Office, Central College, 812 University, Box 5100, Pella, Iowa 50219**