

# WHEATON COLLEGE STUDENT HEALTH SERVICES MEDICAL HISTORY REPORT

**To be completed by Student/ Parent:**

Name: \_\_\_\_\_ ID# \_\_\_\_\_  
Last Name First name MI

Address: \_\_\_\_\_  
Street City State Zip Phone

Date of Entry: \_\_\_/\_\_\_/\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: M [ ] F [ ] Marital Status: S [ ] M [ ] W [ ] D [ ]  
Mo Yr Mo Day Yr

Status: Part-time \_\_\_ Full-time \_\_\_ Graduate \_\_\_ Undergraduate \_\_\_ Special \_\_\_ Consortium \_\_\_ Modular \_\_\_

Have you previously attended Wheaton College [ ] Yes [ ] No If yes, last year of attendance \_\_\_\_\_ Maiden Name \_\_\_\_\_

In case of Emergency Notify: \_\_\_\_\_  
*(Minors must fill this out with guardian in the USA)* Name Address Relationship to student  
Home Phone (with area code) Business Phone (with area code)

**FAMILY HISTORY**

	Age	State of Health	Occupation	Age of Death	Cause of Death	Immediate Family Medical History	Yes	No	Relationship
Father						Arthritis			
Mother						Cancer			
Siblings						Diabetes			
						Epilepsy			
						Heart Disease			
						Kidney Disease			
Spouse									
Children						Stroke			
						Tuberculosis			

**PERSONAL HISTORY:** Please comment on all yes answers in comment section or on an additional sheet.

Have You Had?	Y	N		Y	N		Y	N		Y	N
Allergies, seasonal			Diarrhea, frequent			Hernia			Sleep Disturbance		
Anemia			Dizziness/Fainting			High Blood Pressure			Stomach Disorder		
Arthritis			Ear, nose, throat disorder			HIV/AIDS			Strep throat, recurrent		
Asthma, chronic			Eating disorder			Kidney disorder			Surgery		
Asthma, exercise induced			Epilepsy			Malaria			Appendectomy		
Back Problem			Eye problem			Menstrual problems			Tonsillectomy		
Bronchitis, recurrent			Fracture/Sprain			Mononucleosis			Other		
Cancer			Gallbladder disease			Paralysis			Thyroid disorder		
Chickenpox			Head injury			Pneumonia			Tuberculosis		
Counseling			Headache, recurrent			Rheumatic Fever			Tumor/Cyst		
Depression			Heart condition/Murmur			Sexually transmitted disease			Urinary tract infection		
Diabetes			Hepatitis			Sinus condition			Weight gain/loss, recent		

**HOSPITALIZATIONS:** Reason \_\_\_\_\_ Date \_\_\_\_\_

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**COMMENTS**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

LIST ALLERGIES TO MEDICATIONS, FOODS, POLLEN, MOLDS OTHER:

\_\_\_\_\_

LIST MEDICATIONS/ HERBALS TAKEN REGULARLY: \_\_\_\_\_

\_\_\_\_\_

PLEASE LIST ANY ILLNESS OR INJURY OTHER THAN ALREADY NOTED: \_\_\_\_\_

\_\_\_\_\_

**PARENTAL CONSENT:** The law requires, with certain exceptions, that parental permission be obtained for operative and therapeutic procedures on minors (≤18 years old). The following consent form should be signed by parents so emergency procedures may be carried out promptly, and that no unnecessary delays will occur with less urgent operative procedures. However, no operation will be performed, except in extreme emergency, without parents being contacted and fully informed.

I give permission for such medical procedures as may be deemed necessary for my son/daughter.

Signature of Parent/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

Date Completed \_\_\_\_\_