Admission Health Record Packet

Personal Health History – To be completed by student

Name (Print): ____Date of Birth: _______________
Last First MI Month/Day/Year

To ensure that your treatment needs are met as you transition to SAIC, please indicate if you would like a staff member from the Wellness Center to contact you to review local treatment and referral options? YES ☐ NO ☐

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1. List any illnesses or medical conditions for which you are currently being treated.

Condition Treatment Year Diagnosed

____________________________ ___________________________________ ______________

____________________________ ___________________________________ ______________

____________________________ ____________________________________ ______________

2. List any hospitalizations and/or surgeries.

Hospitalization/Surgery Reason/Indication Dates

____________________________________ _____________________________ ___________________

____________________________________ _____________________________ ____________________

3. List current medications (include vitamins/herbs/non-prescription medications):

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4. List your allergies. Include reactions. **Check if no allergies:** ☐

Medications: ____

Other Allergies: ____

5. Medical History – check all current or past conditions not indicated above:

- ☐ Eye Disease/Defect
- ☐ Hearing Loss / Ear Problem
- ☐ Asthma
- ☐ Heart Disease / Murmur
- ☐ High / Low Blood Pressure
- ☐ Blood or Clotting Disorder
- ☐ Sickle Cell Anemia / Trait
- ☐ Dizziness / Fainting
- ☐ Anemia
- ☐ Ulcer Disease
- ☐ Irritable Bowel Syndrome
- ☐ Digestive Problems
- ☐ Thyroid Disorder
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Arthritis
- ☐ Scoliosis
- ☐ Fractures
- ☐ Joint Injury
- ☐ Neck and / or Back Problem
- ☐ Neurological Disorder
- ☐ Seizure Disorder
- ☐ Recurrent Headaches / Migraine
- ☐ Endocrine Disorder
- ☐ Diabetes
- ☐ Cancer / Malignancy
- ☐ Tuberculosis
- ☐ Hepatitis (Type:_____)
- ☐ Mononucleosis/Epstein-Barr virus
- ☐ Skin Disorder:________
- ☐ ADD / ADHD
- ☐ Drug / Alcohol Problem
- ☐ Tobacco Use
- ☐ Eating Disorder
- ☐ Anxiety Disorder
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Other Mental Illness

Other: ____

6. Family History

Has any family member ever had	**Yes**	**No**	**Relationship**	**Has any family member ever had**	**Yes**	**No**	**Relationship**
Heart Disease/Stroke				High Blood Pressure			
Diabetes				Cancer (specify)			
Kidney Disease				Mental Illness (specify)			
Liver Disease				Alcohol or Drug Problems or abuse			
Seizure Disorder				Thyroid Disease			
Other:							