

OLIVET COLLEGE HEALTH SERVICES
OLIVET, MI 49076
269-749-7392
STUDENT HEALTH RECORD

Name _____ Date of Birth _____ SS# _____
 Home Address _____ City _____ State _____ Zip _____ Phone _____
 Campus Address _____ Campus Phone _____
 Whom to notify in case of an emergency _____ Relationship _____
 Phone number _____

FAMILY HISTORY

Father: Age _____ Health _____ Mother: Age _____ Health _____
 Brothers and Sisters: Number living _____ ages _____
 If any of the above are deceased, please list who, cause of death and age of death _____

Has any blood relatives had:

Cancer	Yes _____ No _____ Who _____	Asthma or Hay Fever	Yes _____ No _____ Who _____
Heart Disease	Yes _____ No _____ Who _____	Allergies	Yes _____ No _____ Who _____
Diabetes	Yes _____ No _____ Who _____	Tuberculosis	Yes _____ No _____ Who _____
High Blood Pressure	Yes _____ No _____ Who _____	Stroke	Yes _____ No _____ Who _____
Ulcer	Yes _____ No _____ Who _____	Alcoholism	Yes _____ No _____ Who _____
Emphysema	Yes _____ No _____ Who _____	Mental Illness	Yes _____ No _____ Who _____
Migraines	Yes _____ No _____ Who _____	Other	_____

PERSONAL HISTORY

Any allergies to medications? Yes _____ No _____ If yes, what? _____
 Any other allergies? _____
 Are you taking any medication now? Yes _____ No _____ What? _____

Do you now, or have you in the past, had any of the following:

Migraine headaches	Yes _____ No _____	Colon or Bowel trouble	Yes _____ No _____
Epilepsy or Convulsions	Yes _____ No _____	Rectal trouble	Yes _____ No _____
Blindness Either Eye	Yes _____ No _____	Hemorrhoids	Yes _____ No _____
Ear Infections	Yes _____ No _____	Serious diarrhea	Yes _____ No _____
Deafness	Yes _____ No _____	Kidney or bladder infection	Yes _____ No _____
Asthma	Yes _____ No _____	Kidney stones	Yes _____ No _____
Hay Fever	Yes _____ No _____	Anemia	Yes _____ No _____
Chronic Bronchitis	Yes _____ No _____	Poor blood clotting	Yes _____ No _____
Emphysema	Yes _____ No _____	Diabetes	Yes _____ No _____
Tuberculosis	Yes _____ No _____	On insulin	Yes _____ No _____
Abnormal chest x-ray	Yes _____ No _____	Gout	Yes _____ No _____
Heart Murmur	Yes _____ No _____	Overactive thyroid	Yes _____ No _____
Enlarged Heart	Yes _____ No _____	Underactive thyroid	Yes _____ No _____
Heart Attack	Yes _____ No _____	Broken bones	Yes _____ No _____
Ulcer	Yes _____ No _____	Arthritis	Yes _____ No _____
Angina	Yes _____ No _____	STD(s)	Yes _____ No _____
High Blood Pressure	Yes _____ No _____	Skin disease	Yes _____ No _____
Hepatitis	Yes _____ No _____	Varicose Veins	Yes _____ No _____
Gall stones	Yes _____ No _____	Have you lost weight recently?	Yes _____ No _____
Cirrhosis of Liver	Yes _____ No _____	Do you have difficulty sleeping?	Yes _____ No _____

SYSTEM REVIEW

Do You Have Any of the Following Complaints?

GENERAL

Fever Yes _____ No _____
Chills Yes _____ No _____
General Weakness Yes _____ No _____
Memory Loss Yes _____ No _____
Swollen Glands Yes _____ No _____
Easy Bruising Yes _____ No _____

HEAD

Blurred Vision Yes _____ No _____
Double Vision Yes _____ No _____
Light Flashes Yes _____ No _____
Halos Around Lights Yes _____ No _____
Pain in Your Eyes Yes _____ No _____
Ear Pain Yes _____ No _____
Drainage from Ear Yes _____ No _____
Hearing Difficulty Yes _____ No _____
Buzzing/Ringing of Ears Yes _____ No _____
Nosebleeds Yes _____ No _____
Sinus Trouble Yes _____ No _____
Difficulty Swallowing Yes _____ No _____
Mouth, Teeth Problems Yes _____ No _____
Persistent Hoarseness Yes _____ No _____
Severe Headaches Yes _____ No _____
Other _____

SKIN

Changing Moles Yes _____ No _____
Rash Yes _____ No _____
Yellow Skin Yes _____ No _____
Other _____

NECK

Swelling Yes _____ No _____
Lumps Yes _____ No _____
Stiffness Yes _____ No _____
Other _____

CHEST, HEART, LUNGS

Shortness of Breath Yes _____ No _____
Frequent Cough Yes _____ No _____
Fluttering of Heart Yes _____ No _____
Unusual Heartbeat Yes _____ No _____
Chest Pain or Pressure Yes _____ No _____
Coughing up Blood Yes _____ No _____
Wheezing Yes _____ No _____

WOMEN

Menstrual Difficulties Yes _____ No _____
Breast disease Yes _____ No _____
Number of Times Pregnant Yes _____ No _____
Number of Miscarriages Yes _____ No _____

GASTROINTESTINAL

Poor Appetite Yes _____ No _____
Indigestion/Heartburn Yes _____ No _____
Difficulty Swallowing Yes _____ No _____
Nausea or Vomiting Yes _____ No _____
Vomiting Blood Yes _____ No _____
Abdominal Pain or Cramps Yes _____ No _____
Abdominal Swelling Yes _____ No _____
Diarrhea Yes _____ No _____
Constipation Yes _____ No _____
Change in Bowel Habits Yes _____ No _____
Pass Blood from Rectum Yes _____ No _____
Black, Tar-like Bowel Movements Yes _____ No _____
Other Yes _____ No _____

KIDNEY

Blood in Urine Yes _____ No _____
Pain or Burning when Urinating Yes _____ No _____
Difficulty Passing Urine Yes _____ No _____
Difficulty Controlling Urine Yes _____ No _____
Getting Up at Night to Urinate Yes _____ No _____

NEUROMUSCULAR

Weakness in Arms or Legs Yes _____ No _____
Difficulty with Balance Yes _____ No _____
Dizzy Spells Yes _____ No _____
Fainting Spells Yes _____ No _____
Speech difficulty Yes _____ No _____

PSYCHOLOGIC

Do You Find Your Life:
Generally Unsatisfactory Yes _____ No _____
Too Demanding Yes _____ No _____
Boring Yes _____ No _____
Satisfactory Yes _____ No _____

Do You Worry About:

Money Yes _____ No _____
Job Yes _____ No _____
Marriage Yes _____ No _____
Home Life Yes _____ No _____
Children Yes _____ No _____

Do You:

Cry Easily Yes _____ No _____
Feel Inferior to Others Yes _____ No _____
Feel Shy Yes _____ No _____
Feel Things Often Go Wrong Yes _____ No _____
Often Feel Depressed Yes _____ No _____
Have Irrational Fears Yes _____ No _____
Feel Anxious or Upset Yes _____ No _____

Have You:

Seriously Considered Suicide Yes _____ No _____
Attempted Suicide Yes _____ No _____

DATE FORM COMPLETED _____