BRIAR CLIFF university

Medical History Form

DATE ______________________

RETURN TO: BRIAR CLIFF UNIVERSITY HEALTH OFFICE • 3303 REBECCA STREET, SIOUX CITY, IA 51104 • 712-279-5436

CHECK APPROPRIATE BOXES ❒ International ❒ Transfer ❒ Athlete - Sport ______________________

NURSING PROGRAM ❒ Basic Program ❒ RN-BSN Program ❒ LPN-BSN Program ❒ Other Program

Name (LAST) ______________________ (FIRST) ______________________ (M.I.) ________ ❒ Male ❒ Female

Date of Birth ______________ SSN# ______________________ Entering as a (circle one): FR SO JR SR GRAD

Home Address ______________________________________ Home Phone (______) ______________

Resident Status (CHECK ONE) Residence Hall ❒ Alverno ❒ Baxter ❒ Noonan ❒ Toller ❒ Room # ________ ❒ Commuter

Commuter Address ______________________________________ Home Phone (______) ______________

Email Address ______________________________________ Cell Phone (______) ______________

Emergency Contact's Name ______________________________________ Home Phone (______) ______________

Contact's Address ______________________________________ Cell Phone (______) ______________

PARENTAL CONSENT FOR EMERGENCIES CARE FOR STUDENTS UNDER 18 YEARS OF AGE

In case of an accident or emergency where there is not time to contact the parents, the university is hereby given authority to make decisions for treatment or surgery.

Parent(s) or Guardian(s) (circle one) Signature: ______________________________________

FAMILY HISTORY

	Names	Age	State of Health	Occupation	Age/Cause of Death
Father					
Mother					
Brother(s)	NA				
Sister(s)	NA				

What relative has had:

Diabetes______________________ Kidney Disease______________________ Cancer______________________

Asthma, Hay Fever______________________ Heart Disease______________________ Mental Illness______________________

High Blood Pressure______________________ Seizures, Convulsions______________________ Tuberculosis______________________

PERSONAL HISTORY (Please answer all questions.)

Have you had . . .	Yes	No		Yes	No		Yes	No		Yes	No
Scarlet Fever	❒	❒	Diabetes	❒	❒	Recurrent Headaches	❒	❒	Back Trouble	❒	❒
Measles	❒	❒	Cancer	❒	❒	Weakness/Paralysis	❒	❒	Bone Fractures	❒	❒
German Measles	❒	❒	Arthritis	❒	❒	Gum/Tooth Trouble	❒	❒	Joint Disease/Injury	❒	❒
Mumps	❒	❒	Tumor, Cyst	❒	❒	Ear Eye Nose Throat	❒	❒	Dizziness/Fainting	❒	❒
Chicken Pox	❒	❒	Convulsions/Seizures	❒	❒	Mononucleosis	❒	❒	Difficulty Sleeping	❒	❒
Malaria	❒	❒	Pneumonia/Bronchitis	❒	❒	Shortness of Breath	❒	❒	Skin Trouble	❒	❒
Tuberculosis	❒	❒	High or Low Blood			Chronic Cough	❒	❒	Surgery (describe below)	❒	❒
Hay Fever/Asthma	❒	❒	Pressure	❒	❒	Stomach/Intestinal			Emotional Problems	❒	❒
Rheumatic Fever	❒	❒	Head Injury	❒	❒	Trouble	❒	❒	Smoker	❒	❒
Heart Murmur	❒	❒	with Unconsciousness	❒	❒	Kidney/Urinary Trouble	❒	❒	Eating Disorder	❒	❒

Please explain any "yes" responses ______________________________________

____

ALLERGIES: Describe known allergies or drug sensitivities ______________________________________

MEDICATION: Prescription, over the counter, supplements, or performance agents you are taking ______________________

____

Have you had any illness or surgery which required hospitalization? YES ❒ NO ❒ EXPLAIN______________________

Have you consulted or been treated by clinic, physician, or other practitioners within the past five years? YES ❒ NO ❒ EXPLAIN______________________

If so, have any of your activities been restricted in the past five years? YES ❒ NO ❒ EXPLAIN______________________

IMMUNIZATION INFORMATION *** Refer to Immunization policy in the student handbook.

- All freshman & transfer students are required to attach a copy of immunization records – please make sure the students name is on the copy.
- If you received any immunizations while attending BCU, please submit a copy to the Health Office.

STATE LAW REQUIRES the following information be submitted for those living in the residence halls.

Meningococcal immunization (Circle one) **NO** **YES** DATE RECEIVED _____/_____/________

Have you received information on meningococcal disease and benefits of the vaccine (Circle one) **YES** **NO**

PHYSICAL EXAM; Recommended for all students • Required for athlete & nursing students

No chiropractor examination will be accepted for nursing.

HEIGHT ________________ WEIGHT ________________ PULSE ________________ BLOOD PRESSURE ______________________________

Lab Work (If desired by physician.)

Urine:Glucose ___________ Protein ________________ Blood __________________ Other _______________________________________

Are there any abnormalities of the following systems?

	Yes	No	Please use this area to describe any positive findings.
Head, Ears, Nose, or Throat	❒	❒	
Respiratory	❒	❒	
Cardiovascular	❒	❒	
Gastrointestinal	❒	❒	
Hernia	❒	❒	
Eyes	❒	❒	
Genitourinary	❒	❒	
Musculoskeletal	❒	❒	
Metabolic/Endocrine	❒	❒	
Neuropsychiatric	❒	❒	
Skin	❒	❒	

Is there loss or seriously impaired function of any paired organ? ❒ Yes ❒ No

Recommendation for physical activity (PE, Athletics, Intramurals) ❒ Unlimited ❒ Limited

If limited, please explain ____

Is the patient now under treatment or medication for any medical or emotional condition? ❒ Yes ❒ No

If yes, please explain ____

____

PRIMARY CARE PROVIDER (PRINT)____

PCP SIGNATURE____ **DATE**______________________

Address____ Phone Number_________________________

- **I acknowledge that Briar Cliff University abides by the Protected Health Information Privacy Act.**

(A copy of the protected Health Information Act is available in the health office.) A signature is required prior to the release of any health information. I hereby authorize Briar Cliff University to release verbally or by documentation from the medical record:

❒ Briar Cliff University Athletic Department (a computerized copy of the Medical History Form is available for the trainer)

❒ Briar Cliff University Nursing Department (a computerized copy of the Medical History Form is available for the Dept. of Nursing)

❒ (Names) of my parents and/or guardian ____

I may withdraw this consent at any time by providing written notice, except that disclosure made is good faith, in reliance on this consent, has already occurred. I hereby authorize the release of information as indicated above.

STUDENT SIGNATURE REQUIRED

PRINT NAME_______________________________________ SIGNATURE____________________________________

DATE____________________