

CONFIDENTIAL HEALTH QUESTIONNAIRE

This form is your Confidential Health Questionnaire and Immunization Record. Completion of this form is required by Student Health Services by the 1st day of class. If you have an illness that requires continuity of care, please have your family physician document this by attached letter so we may continue appropriate individualized treatment for you.

PART I: To be completed by Student - Please Print

US Citizen YES NO, Of what Country _____

Name: Last	First	Middle Initial	Student ID #	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male
Home Address:	City	State	Zip	Date you plan to enroll at Stout: Mo. Yr.	
Parent/Guardian		Home Telephone: () Work Telephone: ()		Are you currently attending Stout? <input type="checkbox"/> yes <input type="checkbox"/> no	
Name of Insurance Company:		Policy #'s:		Year in School _____	

Have you had or are you presently experiencing:

Yes No

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies: Environmental/Others |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemias |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma/Respiratory Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Back Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Location |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting or Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent or Severe Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble/Murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Menstrual Difficulties |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental or Emotional Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen or Painful Joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach or Intestinal Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis/History of Positive
Skin Test _____ mm Reading |
| <input type="checkbox"/> | <input type="checkbox"/> | Infectious Diseases:
(i.e. Infectious Mononucleosis,
Hepatitis, Chicken Pox)
Explain: _____ |

Family Health History (Indicate immediate family member):

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | Member |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack or
Heart Trouble _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Trouble _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke/Blood Clots _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (type) _____ |

Please explain any significant operations, accidents or illnesses/hospitalizations including month/year of occurrence (i.e., tonsillectomy, appendectomy):

List any known drug allergies/reactions:

Describe type of reaction (i.e., rash, stomach distress):

Are you taking any medication regularly? _____

If yes, identify type: _____

Student Signature

Date