

Due: July 1, 2010

Bates College Health History Form

(Confidential)

Health Center
31 Campus Ave.
Lewiston, ME 04240
Phone: 207-786-6199
Fax: 207-786-8240

Please answer every question and return to the Health Center by JULY 1. Complete this form before taking the Physician's Evaluation to your Doctor. Submission of this form is required before matriculation can occur.

M F

Last Name	First Name	Middle Initial	
Date of Birth	Place of Birth	College Class	Social Security No.

EMERGENCY NOTIFICATION

Please provide the name of your parent/guardian and someone to call if a parent/guardian is not available.

1. Father's Name _____ occupation _____
Street _____ City, State, Zip _____
Telephone: home _____ cell phone _____ email _____

2. Mother's Name _____ occupation _____
Street _____ City, State, Zip _____
Telephone: home _____ cell phone _____ email _____

3. Emergency Contact _____ relationship _____
Street _____ City, State, Zip _____
Telephone: home _____ cell phone _____ email _____

Permission for Emergency Treatment

(To be signed by parent, or guardian, or student if 18 years or older)

On occasion, a surgical emergency may arise when we are unable to contact a parent or consult the patient. Anesthesia cannot be administered to, or any operation performed on, a minor without this consent. In order not to delay any procedure necessary to safeguard the health of a student, we request that the following permission be signed.

I hereby grant permission to the College Physician, if I cannot be reached or communicated with, to hospitalize and provide any treatment necessary for my son, daughter, or ward, or myself (cross out terms not applying), according to professional judgment, if further delay might jeopardize health.

Date _____ Signature _____

Next of kin other than parent or guardian to be notified in case of emergency: Name _____

Address _____ Telephone () _____

SOURCES OF HEALTH CARE

Please list the names, addresses and telephone numbers of physicians, psychologists, or other health care providers you now consult.

Name _____	Name _____
Field of Practice _____	Field of Practice _____
Address _____	Address _____
City, State _____	City, State _____
Telephone _____	Telephone _____
Fax _____	Fax _____

ALL MEDICAL RECORDS ARE CONFIDENTIAL.

Health Insurance Info - Please include a copy of the front & back of your insurance card.

Name: _____ Date of birth: _____

LAST

FIRST

PERSONAL HEALTH HISTORY

	Yes	No	Year		Yes	No	Year		Yes	No	Year
Sinustitis				Jaundice or hepatitis				Concussion/head inj.			
Hearing Loss				Kidney or bladder infection				Migraines			
Ear, nose, throat problems				Gallbladder/pancreatic problems				Frequent or severe headaches			
Eye trouble				Kidney stone				Epilepsy, seizures			
Fainting Spells				Missing kidney/paired organ				Paralysis			
Rheumatic Fever				Albumin or blood in urine				Learning disability			
Shortness of breath				Abnormal pap test				ADD/ADHD			
Congenital heart disease				Fibrocystic breasts				Worry or anxiety			
Mitral valve prolapse				Irregular menstruation				Clinical depression			
Pneumonia				Sexually transmitted infection				Mononucleuiss			
Asthma				Neck or back injury				Cigarette/tobacco use			
Chronic cough				Shoulder injury				Tumor or cancer			
TB/Postitive TB test				Arm injury				Obesity			
Skin disease				Knee injury				Eating disorder			
Hernia				Ankle injury				Malaria			
Irritable bowel syndrome				Other leg injury				Anemia or other Blood Disorders			
Stomach or intestinal problems				Arthritis, rheumatism, or bursitis				Other Problems			
Diabetes				Other orthopedic problems							
Thyroid problems				Heat intolerance							

Comments on any YES answers or OTHER PROBLEMS: _____

MEDICAL HISTORY

MEDICATIONS: Please list all (prescription and over-the-counter) including birth control, asthma medication, antidepressants, etc.

ALLERGIES: List known allergies and type of reaction/Epipen?

Medication allergies: _____

Foods: _____

Environmental: _____

HOSPITALIZATION: Have you ever been hospitalized for any surgical, medical or psychiatric illness? yes no

If yes, please specify diagnosis and date _____

Have you received counseling or psychiatric care within the last six years? yes no

Are you taking meds for depression, anxiety, ADD/ADHD, disturbance of mood, thought or behavior? yes no

FAMILY HISTORY

Have parents, siblings, grandparents had any of the following? If adopted and history unkown, check here _____ .

	Yes	No	Relationship		Yes	No	Relationship	Comments
Diabetes				Cancer (type: _____)				
High Blood Pressure				Sickle cell anemia				
Stroke				Thyroid disease				
High Cholesterol				Depression/mental illness				
Heart attack before 55				Liver disease				
Alcoholism				Other serious illness				

If either parent or sibling is deceased, Please list relationship to you, age at death, and cause of death.