



RETURN TO:
 Health Services
 Haverford College
 370 Lancaster Avenue
 Haverford, PA 19041-1392
 610-896-1089
 FAX: 610-896-1090

CONFIDENTIAL HEALTH RECORD

DEADLINE: JULY 21

NAME _____ D.O.B. _____ SEX _____

PERMANENT HOME ADDRESS _____ EMAIL _____

IN CASE OF EMERGENCY NOTIFY _____

HEALTH INSURANCE CO. _____ POLICY # _____ GRP # _____
(name) (phone) (relationship)

FAMILY PHYSICIAN _____
(name) (address) (phone)

ALLERGIES/DRUG, OTHER

- 1 No known allergies
- 2 Aspirin
- 3 Penicillin
- 4 Codeine
- 5 Sulfa
- 6 Latex
- 7 Insect
- 8 Animal
- 9 Food
- 10 Other (please specify) _____

DISABILITY

- NONE
 Do you have an impairment that substantially limits a major life activity, or are you disabled in any way that requires you to receive special consideration from the College? If so, please check the appropriate box and give specifics.
- 1 Vision
 - 2 Hearing
 - 3 Speech
 - 4 Motor
 - 5 Mental or psychological
 - 6 Learning
 - 7 Anatomical loss (please specify) _____
 - 8 Other (please specify) _____

Please explain disability: _____

This information on disability will be shared with the Disabilities Services Coordinator and other appropriate College Offices, as necessary.

FAMILY MEDICAL HISTORY

If any of your blood relatives had the diseases listed, check in the space provided (include parents, grandparents, brothers, sisters)

- 1 Alcoholism
- 2 Anemia
- 3 Bleeding tendency
- 4 Cancer
- 5 Diabetes
- 6 Heart disease
- 7 Hereditary disease
- 8 High blood pressure
- 9 Mental illness
- 10 Migraine
- 11 Obesity
- 12 Stroke
- 13 Sudden death
- 14 Tuberculosis
- 15 Other (please specify) _____

PLEASE CHECK ANY OF THE FOLLOWING IF THEY APPLY:

- Heart Condition
- NONE
- 1 Congenital
- 2 Murmur, uncertain cause
- 3 Mitral valve prolapse syndrome
- 4 Rhematic
- 5 Valvular
- 6 Other (please specify) _____

HAVE YOU EVER HAD/OR DO YOU NOW HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS:

- 1 Acne (under treatment)
- 2 Acquired Immune Deficiency and/or HIV Infection
- 3 Alcoholism
- 4 Anemia
- 5 Anorexia nervosa
- 6 Anxiety
- 7 Asthma
- 8 Bladder infection
- 9 Bleeding trait
- 10 Blood disorders
- 11 Broken bones
- 12 Bulimia
- 13 Cancer or malignancy
- 14 Cardiac abnormalities
- 15 Cerebral palsy
- 16 Chicken pox
- 17 Chronic bronchitis
- 18 Chronic kidney condition
- 19 Compulsive overeating
- 20 Condyloma (genital warts)
- 21 Congenital anomaly
- 22 Constipation
- 23 Crohn's disease, Ulcerative colitis
- 24 Cystic breast disease
- 25 Cystic fibrosis
- 26 Depression
- 27 Diabetes
- 28 Dizziness/fainting
- 29 Drug addiction
- 30 Dysmenorrhea (severe menstrual cramps)
- 31 Eating disorder
- 32 Emotional illness
- 33 Frequent colds
- 34 Gastric ulcer
- 35 German measles (Rubella)
- 36 Head injury
- 37 Headaches
- 38 Hemorrhoids
- 39 Hepatitis
- 40 Hypertension (Elevated blood pressure)
- 41 Infectious mononucleosis (Mono)
- 42 Insomnia
- 43 Irritable bowel syndrome
- 44 Kidney infection
- 45 Knee injury
- 46 Loss of consciousness
- 47 Lyme disease
- 48 Malaria
- 49 Measles (Rubeola)
- 50 Menstrual disorders
- 51 Migraine
- 52 Multiple sclerosis
- 53 Mumps
- 54 Muscular dystrophy
- 55 Obesity
- 56 Parasitical infections
- 57 Pelvic infections
- 58 Phlebitis
- 59 Polio
- 60 Pregnancy
- 61 Psoriasis
- 62 Rheumatic fever
- 63 Rheumatoid arthritis
- 64 Seasonal allergies
- 65 Seizure disorders (Epilepsy)
- 66 Sexual Abuse
- 67 Sexually transmitted diseases
- 68 Systemic lupus erythematosus
- 69 Testicular disease
- 70 Thyroid disease
- 71 Tropical diseases
- 72 Tuberculosis
- 73 Vaginitis
- 74 Worry or nervousness
- 75 Vision problems
- 76 Smoker
- 77 Do you drink alcoholic beverages
- 78 Do you use illicit drugs
- 79 Other (please specify)

PREVIOUS HOSPITALIZATION/PROCEDURES

Please check:

NONE

Yes — indicate reason:

- | | |
|--|--|
| 1 <input type="checkbox"/> Appendectomy | 10 <input type="checkbox"/> Orthopedic surgery |
| 2 <input type="checkbox"/> Breast biopsy | 11 <input type="checkbox"/> Pilonidal cyst |
| 3 <input type="checkbox"/> Gynecological surgery | 12 <input type="checkbox"/> Thyroid |
| 4 <input type="checkbox"/> Hernia | 13 <input type="checkbox"/> Tonsils/Adenoids |
| 5 <input type="checkbox"/> Injury | 14 <input type="checkbox"/> Other (please specify) _____ |
| 6 <input type="checkbox"/> Medical illness | _____ |
| 7 <input type="checkbox"/> Mental illness | _____ |
| 8 <input type="checkbox"/> Mole removal | _____ |
| 9 <input type="checkbox"/> Oral surgery | |

MEDICATIONS

NONE

Please list all medications:

- | | Name | Dose/Frequency |
|--|------------------|----------------|
| 1 <input type="checkbox"/> Over the counter | _____ | _____ |
| 2 <input type="checkbox"/> Prescription | _____ | _____ |
| 3 <input type="checkbox"/> Oral contraceptives | _____ | _____ |
| 4 <input type="checkbox"/> Illicit drugs | _____ | _____ |
| 5 <input type="checkbox"/> Vitamins | _____ | _____ |
| 6 <input type="checkbox"/> Other | _____ | _____ |
| 7 <input type="checkbox"/> Herbal Supplements | _____ | _____ |
| | (please specify) | _____ |

INDICATE YOUR DIETARY PREFERENCE

- | | |
|---------------------------------------|---|
| 1 <input type="checkbox"/> Regular | 4 <input type="checkbox"/> Other (please specify) _____ |
| 2 <input type="checkbox"/> Diabetic | |
| 3 <input type="checkbox"/> Vegetarian | |

HEALTH OPINIONS

Please check one box for each section

- | | Often | Some-
times | Hardly
Ever
or Never | | Often | Some-
times | Hardly
Ever
or Never |
|---|--------------------------|--------------------------|----------------------------|--|--------------------------|--------------------------|----------------------------|
| 1. How often are you ill? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 19. Do you feel weak all over? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you bothered by nervousness? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 20. How often are you in poor spirits? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you feel tired in the morning? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 21. Do you consider yourself nonathletic? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. How often are you unmotivated? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 22. Are you bothered by your looks?
(Too fat, thin, short, tall, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have loss of appetite? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 23. Do you use chewing tobacco or snuff | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does ill health affect the amount
of work you do? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 24. Do you drink alcoholic beverages? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you feel that you are bothered by all
sorts of (different kinds of ailments in
different parts of your body)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Yes | No | |
| 8. Do you have any trouble in getting to
sleep and staying asleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 25. Have you interrupted school or work because
of a physical illness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. How often are you bothered by having
an upset stomach? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have you interrupted school or work because
of an emotional illness? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are you bothered by nightmares | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 27. Did you ever have radiation treatment
as a child | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have spells of dizziness? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 28. Have you ever sought professional counseling
for personal concerns? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Are you bothered by your heart beating hard? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 29. Have you ever had significant exposure to
hazardous substances (e.g. asbestos, benzene,
lead, pesticides, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 30. Are there other aspects of your health that have
caused problems for you or that might require
special arrangements at college?
(Please specify below): | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you tend to lose weight when you
have important things bothering you? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | |
| 15. Are you troubled by your hands sweating
so that they feel damp and clammy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | |
| 16. Are you bothered by shortness of breath when
you were not exercising or working hard? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| 17. Do your hands tremble enough to bother you? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| 18. Are you troubled by cold sweats?
(NOT a hot sweat — you feel a chill,
but you are sweating at the same time.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |

I hereby give permission to the Health Care Providers at Haverford College to prescribe necessary medication and/or perform treatments or operations necessary in the best interest of my health needs. I understand I am responsible for all submission of my bills to insurance companies, incurred medical expenses and notification to parents. I understand that college officials and my parents or guardian will be notified of any serious illness or injury threatening my life.

Signature of Student: _____ Date: _____

Or parent signature if under 18: _____ Date: _____