

**Central Michigan University  
Pre-Entrance Health History Report**

Your health history provides a baseline of essential information for use by University Health Services clinicians in providing health care services that meet your specific needs. This is confidential information for use in consideration of your health status and in no way will affect your admission to the university or your academic standing. This information will not be released to anyone without your authorization, except as required by law. University Health Services urges correction of remedial physical problems, including dental and vision care, prior to your arrival on campus. **Please return the completed forms and your immunization record directly to CMU Health Services, Medical Records, 200 Foust, Mount Pleasant, MI 48859 prior to the start of classes.**

*If you have questions related to the completion of the forms, please call (989) 774-6591.*

Last Name, First, Middle (Please print.):		University ID (if known) Last 4 digits of Social Security if UID unknown	
Home Street Address:	Phone:	Age:	Date of Birth:
City/State/Zip:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	

**A. EMERGENCY CONTACT**

Last Name, First, Middle:	Relationship:
Home Address:	Home Phone:
Work Address:	Work Phone:

**B. FAMILY HISTORY**

**Have any of your parents, grandparents, or siblings had:**      Yes      No      Relationship

Relationship	Age	State of Health	Occupation	Age at Death	Cause of Death	Alcoholism			
Father						Bleeding Disorder			
Mother						Cancer			
Brother (s)						Diabetes 1 or 2			
						Epilepsy/Seizures			
						Hay Fever			
						Heart Disease			
Sister (s)						High Blood Pressure			
						High Cholesterol			
						Kidney Disease			
						Marfan Syndrome			

**C. PERSONAL HEALTH HISTORY:**

**Mark an "X" next to those problems you now have or have had in the past.** (Attach additional sheets if necessary.)

<p><b>ALLERGY</b></p> <p><input type="checkbox"/> Latex    <input type="checkbox"/> Penicillin  <input type="checkbox"/> Serum    <input type="checkbox"/> Sulfa  <input type="checkbox"/> Environmental  <input type="checkbox"/> Insect stings _____  <input type="checkbox"/> Thimerosol  <input type="checkbox"/> Foods (Specify):   <input type="checkbox"/> Other (Specify.):</p> <p><input type="checkbox"/> Anemia  <input type="checkbox"/> Arthritis  <input type="checkbox"/> Asthma  <input type="checkbox"/> Back problem  <input type="checkbox"/> Cancer  <input type="checkbox"/> Chest pain/pressure  <input type="checkbox"/> Chickenpox  <input type="checkbox"/> Chronic cough  <input type="checkbox"/> Diabetes: __ Type 1 __ Type 2  <input type="checkbox"/> Dizziness/fainting  <input type="checkbox"/> Ear/nose/throat problems  <input type="checkbox"/> Eating disorder/concern  <input type="checkbox"/> Epilepsy/seizures  <input type="checkbox"/> Eye problems: __ Contact lenses __ Glasses __ Other (Specify.)  <input type="checkbox"/> Frequent anxiety</p>	<p><input type="checkbox"/> Frequent depression  <input type="checkbox"/> Frequent headaches/migraines  <input type="checkbox"/> Frequent urination  <input type="checkbox"/> Gallbladder problem  <input type="checkbox"/> German Measles (rubella)  <input type="checkbox"/> Gum/dental problems  <input type="checkbox"/> Hay fever  <input type="checkbox"/> Head injury with loss of consciousness  <input type="checkbox"/> Heart murmur  <input type="checkbox"/> Heart problem other:  <input type="checkbox"/> Hernia/rupture  <input type="checkbox"/> High/Low Blood Pressure  <input type="checkbox"/> Hypoglycemia  <input type="checkbox"/> Immune system disorder:  <input type="checkbox"/> Insomnia/sleep disorder  <input type="checkbox"/> Irregular heart rate/arrhythmia  <input type="checkbox"/> Jaundice/liver problems  <input type="checkbox"/> Joint disease/injury  <input type="checkbox"/> Kidney disease  <input type="checkbox"/> Malaria  <input type="checkbox"/> Measles (rubeola)  <input type="checkbox"/> Meningitis: 0 Viral; 0 Bacterial  <input type="checkbox"/> Organ transplant:  <input type="checkbox"/> Palpitations  <input type="checkbox"/> Pleurisy  <input type="checkbox"/> Pneumonia</p>	<p><b>PERSONAL HISTORY Continued</b></p> <p><input type="checkbox"/> Protein/sugar in urine  <input type="checkbox"/> Recent weight loss/gain: ____ lbs.  <input type="checkbox"/> Recurrent colds  <input type="checkbox"/> Recurrent diarrhea  <input type="checkbox"/> Rheumatic fever  <input type="checkbox"/> Scarlet fever  <input type="checkbox"/> Scoliosis  <input type="checkbox"/> Shortness of breath  <input type="checkbox"/> Sickle Cell Anemia/Trait  <input type="checkbox"/> Sinusitis  <input type="checkbox"/> Stomach or intestinal problems  <input type="checkbox"/> Suicide attempt  <input type="checkbox"/> Thyroid problem  <input type="checkbox"/> Trick knee/shoulder  <input type="checkbox"/> Tuberculosis  <input type="checkbox"/> Ulcer  <input type="checkbox"/> Weakness/paralysis  <input type="checkbox"/> Worry or nervousness, severe  <input type="checkbox"/> Other (Specify.):</p> <p><input type="checkbox"/> Surgery  <input type="checkbox"/> Appendectomy    <input type="checkbox"/> Hernia Repair  <input type="checkbox"/> Tonsillectomy    <input type="checkbox"/> Other (Specify.):</p> <p><input type="checkbox"/> Hospitalizations (Specify.)</p>
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**Continue on other side**

HS 275A (05/29/09R)

<b>D. Distinguishing Marks (scars, tattoos, piercings)</b>			
Size	Location	Description	
<b>E. Health Promotion/Disease Prevention Measures</b>			
Special Diet:		Regular Exercise: <input type="radio"/> No <input type="radio"/> Yes Type(s):	
		How often?	How long at a time?
Caffeine (coffee, tea, soda, chocolate): How much daily?			
Use of Sunscreen SPF ≥ 15: <input type="radio"/> Always <input type="radio"/> Usually <input type="radio"/> Sometimes <input type="radio"/> Rarely <input type="radio"/> Never			
Use of Tanning Booth: <input type="radio"/> No <input type="radio"/> Yes	How often?	Length of Sessions	Years of Use
Use of Seatbelt : <input type="radio"/> Always <input type="radio"/> Usually <input type="radio"/> Sometimes <input type="radio"/> Rarely <input type="radio"/> Never			
Smoking or Smokeless Tobacco Use: <input type="radio"/> No <input type="radio"/> Yes		How much?	For how long?
Alcohol Use:			
Men: How many times in the past year have you had 5 or more drinks in a day? _____			
Women: How many times in the past year have you had 4 or more drinks in a day? _____			
<b>F. PLEASE ANSWER ALL QUESTIONS BY MARKING AN "X" IN THE "YES" or "NO" COLUMN.</b> Comment below on "Yes" answers. (Attach additional sheets if necessary.)			
	<b>NO</b>	<b>YES</b>	<b>COMMENTS</b>
1. Has your physical activity been restricted during the past 5 years?			
2. Have you received treatment or counseling for a nervous condition, personality or character disorder or emotional problem? (If so, please specify.)			
3. Have you had any illness or injury or been hospitalized for any reason not already noted? (Please list.)			
4. Have you consulted or been treated by clinics, physicians, healers or other practitioners in the past 5 years, other than for routine check-ups? (If so, please specify.)			
5. Have you been rejected or discharged from military Service because of physical, emotional, or other reasons? (If so, please give reasons.)			
6. Do you have any health problems that require periodic testing or evaluation? (Please specify.)			
7. Please list any current medication you are taking, including prescription drugs, over the counter medications, herbs, vitamins, and other supplements. (Add a separate sheet if necessary.)			
<b>G. STUDENT:</b> Please sign below to verify that you have completed the form and that, to the best of your knowledge, the information is accurate and complete.	<b>H. PARENT or GUARDIAN'S SIGNATURE</b> (if student is younger than age 18 years):		
_____	I hereby give permission for such necessary and emergency care as is indicated to be given to my child (son/daughter/ward) by Central Michigan University Health Services and affiliated providers.		
Signature _____ Date _____	Signature _____ Date _____		
<b>Return completed form in a sealed envelope to:</b> <b>Central Michigan University Health Services</b> <b>Medical Records</b> <b>200 Foust</b> <b>Mount Pleasant, MI 48859</b>	_____ Printed Name of Parent/Guardian		

