

Edinboro University of Pennsylvania CONFIDENTIAL HEALTH RECORD

Information provided will not be used to influence your situation at the University. It will be used, if necessary solely as an aid to providing necessary health care while you are a student. This information is strictly for the use of the Health Services and will not be released to anyone without your knowledge and consent.

Name: _____ SS# _____ Date of Birth _____ Sex _____

Permanent Home Address: _____
Street City State Zip

In Case of (1) _____
 Emergency Name Relationship Area Code & Phone #
 Notify Address _____

(2) Name _____
 Address _____
Street City State ZIP

ALLERGIES: Medication/Other – Check or fill in appropriate boxes

Aspirin	Sulfa	Food-	Animals-
Penicillin	Codeine	Pollen	Other-

FAMILY Medical History: If any of your blood relatives had the disease listed, check in the space provided. (include parents, grandparents, and brothers or sisters.)

Alcoholism	Tuberculosis	Stroke	Other (specify)
Anemia	Mental Illness	Diabetes	Other
Bleeding Tendency	Migraines	Heart Disease	Other
Cancer	Obesity	High Blood Pressure	None

PERSONAL MEDICAL HISTORY: Have You Had Any of the Following Medical Conditions?

ADD/ADHD	Chronic Bronchitis	Heart Murrur	Phlebitis
Acne	Chronic Inflammatory Bowel Dis	Hepatitis	Pregnancy
Alcohol or Drug Problem	Chronic Tonsillitis	Hypertension (High BP)	Prostatitis
Anemia	Colds (frequent)	Mononucleosis	Rheumatic Fever
Anorexia Nervosa	Crohn's Disease	Insomnia	Rheumatoid Arthritis
Anxiety	Depression	Joint/Bone Disease	Scarlet Fever
Arthritis	Dermatology Problems	Joint/Bone Injury	Seizure Disorder/Epilepsy
Asthma	Diabetes	Kidney Infection	Sinusitis
Back Problems	Diarrhea (Recurrent)	Kidney Stones	Sexually Transmitted Dis
Binge Eating	Digestive Troubles	Menstrual Cramps	Systemic Lupus Erythematosus
Bladder Infection	Dizziness/Fainting	Menstrual Disorders	Thyroid Disease
Bleeding Trait	Ear Problems	Migraine	Ulcerative colitis
Blood Clots	Eye Problems	Multiple Sclerosis	Worry/Nervousness
Blood Disorders	Hay fever/Allergies	Muscular Dystrophy	HIV/AIDS
Bulimia	Headaches (Recurrent)	Obesity	Other-Specify
Cancer/Malignancy	Head Injury	Pelvic Infection	Surgeries-Specify
Cerebral palsy	Heart Condition	Peptic Ulcer	

DISABILITY- Do you consider yourself handicapped or disabled in any way that requires you to receive special consideration from the University? If so please check the appropriate box and give specifics.

Vision	Other Motor	Other- Specify
Hearing	Emotional	
Mobility	Learning	

Please explain your disability: _____

List any medication you are currently taking on a regular basis: _____

List any condition currently under treatment: _____

Signature _____

Student Id# _____

EDINBORO UNIVERSITY OF PENNSYLVANIA

The Report of the Health Evaluation **MUST** be on file with the director of health services at Edinboro University prior to the student's enrollment date.

Return to: Student Health Services
Ghering Health & Wellness Center
320 Scotland Road
Edinboro, PA 16444

REPORT OF HEALTH EVALUATION

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete the physician's form. Please comment on all positive answers. This information is strictly for the use of the Health Services and will not be released without student consent.

Student's Name _____ SS# _____

IMMUNIZATION DOCUMENTATION

VACCINE	DATES		
DPT- Initial series of 3 injections Required	#1	#2	#3
Td (Tetanus-Diphtheria)- Booster within past 10 years			
Polio- Series of 3 Doses	#1	#2	#3
MMR- 2 Doses	#1	#2	
Hepatitis B 3 Doses	#1	#2	#3
Hepatitis A 2 Doses	#1	#2	
Meningitis Vaccine			
Other			

Last Tuberculin Skin Test- Date _____ Result _____

BP = / Height _____ Weight _____ lbs. Corrected Vision- Right- 20/ Left- 20/

Urinalysis: Sugar _____, Albumin _____, Micro. _____

Hemoglobin (if indicated) _____

Are there any abnormalities of the following systems? Describe fully. Use additional sheet if necessary.

YES NO

	YES	NO
Head, Ears, Nose, Throat		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Eyes		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neuropsychiatric		
Skin		

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

Have you any general comments?

Recommendations for physical activity (PE, Intramurals, ROTC) Unlimited _____ Limited _____ Explain: _____

Do you have any recommendations regarding care of this student? Yes _____ No _____

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

PHYSICIAN'S SIGNATURE _____

ADDRESS _____ Phone # _____

PRINT LAST NAME _____ DATE _____