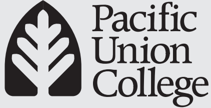
Name ____________

ID # ____________

HEALTH INFORMATION FORM



Return this form to:
Pacific Union College
Health Services
One Angwin Avenue
Angwin, CA 94508
Attn: Health Services
Phone 707.965.6339
Fax 707.965.6243

Deadlines for submitting form:

Fall Quarter Aug. 1
Winter Quarter Nov. 15
Spring Quarter Feb. 1
Summer Quarter May 15

All information must be completely filled out before submitting

Check one of the following:

☐ First Year (never attended PUC before)

☐ Returning Student (last school year attended _____)

PLEASE PRINT IN INK

Full Legal Name ____

Last First Middle

Date of Birth _____ / _____ /_____ Sex ______________ Social Security No. ______________

Street Address ____

City, State, Zip ______________________ Home Phone # ______________

Next of kin or person to be notified in emergency (off campus):

Name ______________________ Relationship ______________

Street Address ____

City, State, Zip ______________________ Home Phone # ______________

Work Phone # ______________

Person to be notified in emergency (on campus):

Name ______________________ Phone # ______________

Insurance Information (attach copy of front and back of your primary insurance card)

Do you have insurance: ☐ No ☐ Yes

(If No, you will be responsible for any treatment outside of Health Services. Please refer to www.puc.edu/healthservices)

Primary Insurance Company Name ______________________

Insured Party's (Policy Holder) Name ______________________

Relationship to Patient ______________________

Policy Number ______________________

*Every effort will be made to assist in the billing of outside medical services. In the event that your insurance does not cover required medical care, the primary policy holder will be billed for services rendered.

CHILDHOOD IMMUNIZATION RECORD: (Please attach copy of documented immunization record)

DPT	______	______	______	______	______
MMR	______	______	______	______	______
Polio	______	______	______	______	______
Hepatitis B	______	______	______	______	______

MEDICAL INFORMATION

List any allergies to medication ______________________

List all medication taken regularly ______________________

List all major injuries/hospitalizations ______________________

Name ____________________

ID # ____________________

PERSONAL HISTORY

Check (X) in box indicating you have had the following and give date, if applicable:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ ADD/ADHD
- ☐ Back trouble
- ☐ Brain concussion
- ☐ Cancer
- ☐ Chickenpox
- ☐ Colds (frequent)
- ☐ Colitis
- ☐ Constipation
- ☐ Diabetes
- ☐ Eating disorder
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fainting spells
- ☐ Fatigue
- ☐ German measles
- ☐ Glandular disorder
- ☐ Hay fever
- ☐ Headaches
- ☐ Hepatitis
- ☐ Hernia or rupture
- ☐ High blood pressure
- ☐ Influenza
- ☐ Jaundice
- ☐ Measles
- ☐ Meningitis
- ☐ Mental illness
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Nervousness
- ☐ Pneumonia
- ☐ Poliomyelitis
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Sinusitis
- ☐ Sleeplessness
- ☐ Sore throat (frequent)
- ☐ Suicide attempts
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid
- ☐ Ulcers (stomach/duodenal)
- ☐ Whooping cough
- ☐ Born or raised in foreign country
  Where? ____________________
- ☐ Other ____________________

____

____

____

____

FAMILY HISTORY

Check (X) in box indicating the illnesses your blood relatives have or have had (Indicate which relative):

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ ADD/ADHD
- ☐ Bleeding trait
- ☐ Cancer
- ☐ Colitis
- ☐ Congenital defect
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Leukemia
- ☐ Mental illness
- ☐ Migraine headaches
- ☐ Nervous breakdown
- ☐ Obesity (20 lbs overweight)
- ☐ Peptic ulcer
- ☐ Sickle cell anemia
- ☐ Suicide or attempts
- ☐ Thyroid disease
- ☐ Tremors, palsy
- ☐ Tuberculosis
- ☐ Other ____________________
- ☐ Other ____________________
- ☐ Other ____________________

TREATMENT AUTHORIZATION FOR PERSONS OVER 18 YEARS OLD

I give my permission to Pacific Union College Health Services department and its staff to provide medical care in the event of an illness/injury sustained while I am a student. I also authorize obtaining pertinent medical information from my primary care provider if indicated.

Signature: ____ Date: ____________________

Applicant

TREATMENT AUTHORIZATION FOR PERSONS UNDER 18 YEARS OLD

(I) (We), the undersigned, parent(s)/guardian(s) do hereby give permission to the Health Services department of Pacific Union College and its staff to provide necessary medical care in the event of an illness/injury sustained by our child. Our signature also gives authorization to obtain pertinent medical information from our child's primary care provider if indicated.

Signature: ____ Date: ____________________

Parent or Guardian

Name ______________________

ID # ______________________

PHYSICAL EXAMINATION

The following to be completed by doctor's office staff:

Height: ______________ **Weight:** ________________

Hearing Evaluation:

Right __________ Left __________

Vision Screening:

Without glasses/With glasses (circle)

Right _________ / _________

Left _________ / _________

Urinalysis:

Blood Neg ____________

Bilirubin Neg ____________

Ketones Neg ____________

Protein Neg ____________

Nitrite Neg ____________

Glucose Neg ____________

pH ____________

Specific Gravity ____________

Leukocytes Neg ____________

Hemoglobin _______

T ______________

P ______________

R ______________

B/P _____________

TB Test (within the last year)

Lot # ___________________ exp. _______________

Date given ______________ Date read ________________

Induration/reading _____________ Read by _____________

If you have recently been out of the United States, please have one done now. PPD must be negative-10mm or less.

Date of last chest X-ray ______________________________

Results ______________________________________

Current Medications: ____________________________

____

Nurse's Signature __________________________________

To be filled out by physician:

Normal	Clinical Evaluation	Abnormal
	Head, Face & Scalp	
	Nose & Sinuses	
	Neck	
	Mouth & Throat	
	Ears	
	Eyes	
	Lungs & Chest	
	Breast	
	Heart	
	Vascular System	
	Abdomen	
	Rectum	
	Endocrine	
	G.U. System	
	Extremities	
	Musculoskeletal	
	Skin	
	Neurological	
	Emotional	

Remarks (please describe each abnormality) ______________________________________

____

____

Date of examination ________________

Signature: ____ Date: ____________

Physician

Name of physician: ______________________________ Street Address ________________

City, State, Zip______________________________ Phone # ______________ Fax # ______________