

Name: _____

PUC 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). Starting quarter: Fall Winter Spring Summer
- 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 # _____ Cell 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)

It is mandatory that all students carry their own medical insurance plan. Please refer to our website www.puc.edu/campus_services/health_services for additional information.

Primary Insurance Company Name _____

Insured Party's (Policy Holder) Name _____

Relationship to Patient _____

Policy Number _____ Insurance Company Phone # _____

*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: (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 _____

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PERSONAL HISTORY

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

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

FAMILY HISTORY

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

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

**CONSENT FOR TREATMENT/FINANCIAL RESPONSIBILITY/ RELEASE OF INFORMATION /
NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT**

I give my consent for medical treatment provided by the Health Services department of Pacific Union College.

I authorize the Health Services department to bill for services rendered either through my student account or my primary medical insurance when indicated. I also authorize the release of past medical information when necessary for the establishment of a treatment plan. My signature also authorizes the release of medical information to those involved in the delivery of care according to my treatment plan.

I certify that the information I have reported with regard to my insurance coverage is correct and agree to notify the Health Services department of any changes in my coverage while attending Pacific Union College. In the event that I have a lapse in coverage or submitted coverage is not adequate I assume full financial responsibility for the treatment provided.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and health information used by us in any form are kept confidential. This act gives patients seen significant new rights to understand and control how your health information is used. HIPPA provides penalties for misuse of personal health information. If you wish to review these rights we can provide you with a copy of the HIPPA Privacy Practice through our office.

You have the following rights with respect to your health information:

- The right to access, inspect, and request a copy of your health records.
- The right to request an amendment to your health information.
- The right to receive and account for certain disclosures of your health information.
- The right to receive confidential communications.
- The right to request restrictions on disclosures concerning your health information.

I hereby consent that medical information and treatment can be discussed with the following person/persons. (If you request information to be discussed only with you please leave the following section blank).

Name: _____ Date listed: _____

Relationship to student: _____

Name: _____ Date listed: _____

Relationship to student: _____

Name: _____ Date listed: _____

Relationship to student: _____

Signature of student (over 18): _____ Date: _____

Signature of parent (under 18): _____ Date: _____

Name: _____

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PHYSICAL EXAMINATION

The following to be completed by doctor's office staff. All information below is required. Please do not leave any section blank. We cannot accept "not applicable" in any category listed below.

Height: _____ **Weight:** _____

Hearing Evaluation:

Right _____ Left _____

Vision Screening:

Without glasses/With glasses (circle)

Right _____ / _____

Left _____ / _____

Urinalysis:

Blood Neg _____ Hemoglobin _____

Bilirubin Neg _____ T _____

Ketones Neg _____ P _____

Protein Neg _____ R _____

Nitrite Neg _____ B/P _____

Glucose Neg _____

pH _____

Specific _____

Gravity _____

Leukocytes Neg _____

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 _____

Remarks (please describe each abnormality) _____

Date of examination _____

Physician's Signature: _____ Date: _____

Name of physician: _____ Street Address _____

City, State, Zip _____ Phone # _____ Fax # _____

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	