

ARCADIA UNIVERSITY

To the Student: YOU HAVE BEEN ACCEPTED TO ARCADIA UNIVERSITY. Information you provide will not be used to influence your situation at the University; it will be used solely as an aid to providing necessary health care while you are a student. This information is strictly for the use of Student Health Services and will not be released to anyone without your knowledge and consent.

REPORT OF MEDICAL HISTORY

Please complete this page before going to your health care provider for the physical examination. Your health care provider must complete the Physical Examination and Immunization records.

LAST NAME (Print) FIRST NAME MIDDLE INITIAL SOCIAL SECURITY NO.

FAMILY HISTORY

	Age	State of Health	Occupation	Age/Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				

Have any of your relatives ever had any of the following:

	Yes	No	Relationship
Diabetes			
Heart Disease/Stroke/High Blood Pressure			
Cancer			
Asthma/Allergies			
Tuberculosis			
Alcohol/Drug Problem			
Depression			

PERSONAL HISTORY – PLEASE ANSWER ALL QUESTIONS – Please comment on all positive answers below (Use additional sheet if necessary)

Have you had?	Yes	No
Chicken Pox		
Measles		
German Measles		
Mumps		
Mononucleosis		
More than 10 lb. weight gain or loss in past year		
Females: menstrual problems		

Have you had?	Yes	No
Dental problems		
Eye problems		
Ear, nose, throat problems		
Asthma		
Seasonal Allergies		
Other medical problems (list):		

Have you had?	Yes	No
Head injury or Concussion		
Epilepsy/ seizures		
Migraines		
Anxiety or depression		
Sleep difficulty		
Eating disorder		
Alcohol/drug problem		
Learning disability		

Have you had?	Yes	No
Diseases/injury of joints		
Back problems		
Heart trouble/high blood pressure		
Stomach/intestinal problems		
Liver or kidney problems		
Skin problems		
Tumors or cysts		
Cancer		
Diabetes		

SOCIAL HISTORY (Comment below or use additional sheet if necessary)	Yes	No
Do you drink alcohol?		
Do you smoke cigarettes, cigars or use smokeless tobacco?		
Do you take medications on a regular basis? (List)		
Has your physical activity been restricted during the past five years? (Explain)		
Have you received treatment or counseling for alcohol or drug abuse, an eating disorder, depression or any other emotional problem? (Explain) Have you been hospitalized for any of the above?		
Have you had any significant illness or injury for which you have been treated or hospitalized other than already mentioned? (Explain)		
Do you have any additional information regarding your health, family history, or other matters:		

DRUG ALLERGY	Type of Reaction	Type of Reaction
<input type="checkbox"/> None		<input type="checkbox"/> Sulfa
<input type="checkbox"/> Codeine		<input type="checkbox"/> Penicillin or Ampicillin
<input type="checkbox"/> Other Please Specify:		<input type="checkbox"/> Food allergy – please specify

ALLERGY INJECTIONS:

You may visit the website to download a consent form and a copy of our policy regarding allergy injections at www.arcadia.edu/student/ and check the Health Services tab on the left of the webpage. Alternatively you can call the Student Health office (215-572-2966) to receive the form by mail.

Student's Signature

Health Care Provider's Signature (Acknowledging Review)

Date

REMARKS OR ADDITIONAL INFORMATION (Use additional sheet if necessary)