St. Luke's College
UnityPoint Health

# Student Health Record


The completion of this Health Form and fulfillment of immunization requirements are required for all students. This form must be completed and submitted to health services for approval prior to starting classes.

**Please print all information legibly**.

## Applicant Information:

Applicant Name:

(Last) (First) (Middle)

Date of birth: SSN: Sex: Male Female

Address:

(Street) (City) ( State) (Zip)

Phone:

(Home) (Cell) ( Work)

Emergency Contacts:

(Name and relationship to you) (Phone)

(Name and relationship to you) (Phone)

Do you have health insurance? Yes No Do you have a personal physician? Yes No

If yes, physician name and address:

# Medical History

**Circle YES if any applies to you currently OR in the past. Please explain any YES answers in the space provided below**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Asthma | Y N | Chest pain/ pressure | Y N | High or Low blood pressure | Y N | Skin rash/ eczema | Y N | Measles, Mumps or Rubella | Y N |
| Diabetes | Y N | Chronic cough | Y N | Kidney disease | Y N | Stroke | Y N | Mononucleosis | Y N |
| Back or neck problems | Y N | Chills/Fever Night Sweats | Y N | Seizure Disorder/ Epilepsy | Y N | Hepatitis/Liver problems | Y N | Anxiety/Panic attacks | Y N |
| Joint injury/ disease | Y N | Dizziness or fainting | Y N | Headaches | Y N | Tendon or ligament injury | Y N | Serious Motor vehicle accident | Y N |
| Broken bones | Y N | Stomach or digestion issues | Y N | Lung problems | Y N | Ear, nose or throat issues | Y N | | Y N |
| Cancer/ cyst/tumor | Y N | Heart problems | Y N | Varicose Veins | Y N | Frequent sinus infections/colds | Y N | | Y N |

**Explain any "yes" answer in the space below:**

**Other comments or information not listed above:**

| | | |
|---|---|---|
| Will you need any special medical assistance? Yes No<br>Explain: | Do you have any psychological, emotional or eating disorders? Yes No<br>Explain: | Do you have any vision or hearing problems? Yes No<br>Explain: |
| Are you allergic to any medications? Environmental or Food Allergies?<br>Latex? Yes No<br>List: | Have you ever been rejected or discharged from military duty due to physical, emotional or other reasons? Yes No<br>Explain: | Please list any surgeries or hospitalizations: |
| Are you being followed by a physician or medical practitioner for any health issue? Yes No<br>Explain: | Have you ever had a positive TB test or are currently experiencing any of the following symptoms: night chills, loss of appetite, fever, weight loss, weakness or cough?<br>Yes No | Please list any medications you take: |
| **Female students:**<br>Irregular periods Yes No<br>Severe cramps Yes No<br>Excessive flow Yes No<br>Pregnancies Yes No<br>If yes, how many? _____<br>Nursing Yes No | | |

**Truth and disclosure statement and signature**

The preceding answers are true and accurate to the best of my knowledge and ability. I understand this will become a part of my health file at St. Luke's College. I also understand that it is my responsibility to keep St. Luke's Student Health updated if any changes occur to the above information promptly. This information will only be retained while enrolled at St. Luke's College. Upon graduating or leaving any program the information will be returned.

**Students' Signature:**_____ **Date:** _____

**NOTICE: READ THE FOLLOWING VACCINE INFORMATION CAREFULLY!**

**St. Luke's College REQUIRES your vaccinations be up to date prior to starting.**

**If you have any questions regarding the vaccine information please contact the student health department ASAP!**