Widener University

One University Place
Chester, PA l9013

Please Print/Type

Date: ____ / ____ / ____

Gender: Man ◯ Woman ◯ Transgender ◯ Self Identify ◯

Last Name First Name Middle Student ID #

/ /

Home Address (Number & Street) City or Town State Zip Code Date of Birth

Undergraduate/Graduate Expected Year of Graduation Program of Study

Home Telephone Cell Phone Number Home Email Address

Emergency Contact Person Telephone Number Relationship

FAMILY HISTORY

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

| | Age | State of Health | Age of Death | Cause of Death |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brothers | | | | |
| | | | | |
| | | | | |
| Sisters | | | | |
| | | | | |
| | | | | |

| | Yes | No | Relationship |
|---|---|---|---|
| Tuberculosis | | | |
| Diabetes | | | |
| Kidney Disease | | | |
| Heart Disease | | | |
| Stomach Disease | | | |
| Asthma, Hay Fever | | | |
| Epilepsy, Convulsions | | | |
| Cancer | | | |
| Sickle Cell Disease/Trait | | | |

Please answer all questions-Comment on all positive answers on the back of the sheet.

**PERSONAL HISTORY PLEASE ANSWER ALL QUESTIONS**

| Have you had? | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Asthma | | | Chest Pain | | | Stomach Ulcer | | | Recent Weight Gain | | |
| Diabetes | | | Palpitations (heart) | | | Hernia | | | Recent Weight Loss | | |
| High Blood Pressure | | | Irregular heart beat | | | Bladder/Kidney Infection | | | | | |
| Low Blood Pressure | | | Rheumatic Fever | | | Back Pain/Injury | | | Insomnia | | |
| Immune System Deficit | | | Heart Murmur | | | Disease or injury of Joints | | | Do you smoke tobacco? | | |
| Head injury with/without unconsciousness | | | Bronchitis | | | Fractures | | | Do you chew tobacco? | | |
| Seizures | | | Pneumonia | | | Bleeding Disorders | | | Do you drink alcohol? | | |
| Anxiety | | | Shortness of Breath | | | Anemia (iron deficiency, sickle cell, etc.) | | | Do you exercise regularly? | | |
| Depression | | | Tuberculosis | | | Sickle Cell Trait | | | Do you have a special diet restriction? | | |
| Anorexia/Bulimia | | | Sinusitis | | | Tumor, Cancer or Cyst | | | | | |
| Bipolar Disease | | | Seasonal Allergies | | | Eczema | | | | | |
| Psychiatric Admission | | | Environmental Allergies | | | Sexually Transmitted Infections (STI) | | | **Females** *Do you or have you had?* | | |
| ADD/ADHD/Dyslexia | | | Eye Disorder/Blindness | | | Malaria | | | Irregular Periods | | |
| Chicken Pox | | | Glasses/Contacts | | | Mononucleosis | | | Abnormal Pap Smear | | |
| Migraines | | | Gall Bladder Disease | | | Hepatitis A,B,C, or D | | | Breast Mass/Cyst | | |
| Neck Injury | | | Chron's Disease | | | Hearing Deficit | | | | | |
| Dizziness or Fainting | | | Irritable Bowel Syndrome (IBS) | | | Throat or Ear Infections | | | **Males** *Do you or have you had?* | | |
| Weakness or Paralysis | | | Diarrhea/Constipation | | | Thyroid Disease | | | Prostate Disease | | |
| Cardiac Disease | | | Gastritis/GERD | | | Loss of Appetite | | | Lump or Mass in Testicle | | |

**This information is strictly for the use of the Student Health Services and will not be released to anyone without your consent.**

Medical History - Comments on any positive responses from front page._____

_____

Surgical History - Please note dates and types of procedures. If not applicable, please indicate by writing NONE.

Medications - List all including: prescription, over the counter and alternative therapy drugs. If not applicable, please indicate by writing NONE.

Please list Physician (s) Telephone Fax Number

| | Yes | No | Remarks or Additional Information |
|---|---|---|---|
| Are you allergic to any medications? Please list: | | | |
| Allergies (Food, insect stings, environmental or other) | | | |
| Have you had any illness, injury or hospitalization other than already noted? (Provide details) | | | |
| Have you consulted or been treated by Physicians or other healthcare providers within the past five years (other than routine check-ups)? | | | |
| | | | |
| Have you received psychological treatment or counseling? (Provide details)<br><br>Diagnosis: _____<br>Medication: _____<br>Psychiatrist Name: _____<br>Psychiatrist Number: _____<br>Counselor Name: _____<br>Counselor Number: _____ | | | |

## Important Notice:

***If you will be under age 18 when you start at Widener University, your parent or legal guardian must sign the statement below. This will allow our providers to offer you health care services while you are at the University.***

I hereby give the Widener University Health Care Providers permission to treat my son/daughter, _____
(Print student's name clearly)
while at the University prior to his/her eighteenth birthday. In the event of an EMERGENCY, I give permission to the Health Services staff and its affiliated hospital to secure for the above named student appropriate treatment, including orders for surgery and anesthesia if indicated.

_____ _____ / _____ / _____

Parent Signature Print Name of Parent/Guardian Date

*Commitment to your privacy:*

Our practice is dedicated to maintaining the privacy of your individual identifiable health information and will maintain its strict confidentiality. Release of health information will only be in response to your signed request, subpoena and/or a life-threatening situation.

This form has been completed truthfully to the best of my knowledge.

_____ / /

Student's Signature Date

_____

Reviewed by Widener University Staff Member

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