

PARTON HEALTH CENTER – SUMMER

Personal and Confidential Health Form

Name: _____ **Date of Birth:** _____

Program: Language School Bread Loaf School of English Bread Loaf Writers' Conference

PERSONAL HEALTH HISTORY

| | Yes | No | Year | | Yes | No | Year | | Yes | No | Year |
|--------------------------------|-----|----|------|------------------------------------|-----|----|------|---------------------------------|-----|----|------|
| Sinusitis | | | | Jaundice or hepatitis | | | | Eating disorder | | | |
| Hearing Loss | | | | Kidney or bladder infection | | | | Migraines | | | |
| Ear, nose, throat problems | | | | Gallbladder/pancreatic problems | | | | Frequent or severe headaches | | | |
| Eye trouble | | | | Kidney stone | | | | Epilepsy, seizures | | | |
| Fainting Spells | | | | Missing kidney/ paired organ | | | | Concussion/ head inj. | | | |
| Rheumatic Fever | | | | Albumin or blood in urine | | | | Learning disability | | | |
| Shortness of breath | | | | Abnormal pap test | | | | Attn Deficit Disorder | | | |
| Congenital heart disease | | | | Fibrocystic breasts | | | | Worry or anxiety | | | |
| Mitral valve prolapse | | | | Irregular menstruation | | | | Clinical depression | | | |
| Pneumonia | | | | Sexually transmitted infection | | | | Alcohol or drug use | | | |
| Asthma | | | | Neck or back injury | | | | Cigarette/tobacco use | | | |
| Chronic cough | | | | Shoulder injury | | | | Tumor or cancer | | | |
| TB/Positive TB test | | | | Arm injury | | | | Obesity | | | |
| Skin disease | | | | Knee injury | | | | Positive HIV test | | | |
| Hernia | | | | Ankle injury | | | | Malaria | | | |
| Irritable bowel syndrome | | | | Other leg injury | | | | Anemia or other Blood Disorders | | | |
| Stomach or intestinal problems | | | | Arthritis, rheumatism, or bursitis | | | | mononucleosis | | | |
| Diabetes | | | | Other orthopedic problems | | | | vegetarian | | | |
| Thyroid problems | | | | Heat intolerance | | | | paralysis | | | |

Comment on any YES answers: _____

MEDICAL HISTORY

Date of last Tetanus Vaccine: _____

Medications: list all medications that you take regularly. Include birth control pills, psychiatric medications, vitamins and minerals, nonprescription medications and supplements: _____

Allergies: list known allergies and type of reaction. _____

Hospitalizations: Have you ever been hospitalized for any surgical, medical or psychiatric illness?

NO YES: Diagnosis and date: _____

History of counseling or psychiatric care within the last six years:

NO YES: Diagnosis and date: _____

FAMILY HISTORY

Have parents, siblings or grandparents had any of the following?

| | Yes | No | Relationship | | Yes | No | Relationship | Comments |
|------------------------|-----|----|--------------|---------------------------|-----|----|--------------|----------|
| Diabetes | | | | Cancer (type:) | | | | |
| High Blood Pressure | | | | Sickle cell anemia | | | | |
| Stroke | | | | Thyroid disease | | | | |
| High Cholesterol | | | | Depression/mental illness | | | | |
| Heart attack before 55 | | | | Liver disease | | | | |
| Alcoholism | | | | Other serious illness | | | | |

If parent or sibling is deceased, please list relationship to you, age at death, and cause of death:

If you are adopted and your health history is unknown, check here .

SOURCES OF HEALTH CARE

(Include physicians, psychiatrists or other health care providers)

| | |
|--------------------|--------------------|
| Name: | Name: |
| Field of Practice: | Field of Practice: |
| Address: | Address: |
| City: State: | City: State: |
| Telephone: | Telephone: |
| Fax: | Fax: |

EMERGENCY NOTIFICATION

Please provide the name of your parent/guardian and someone to call if a parent/guardian is not available.

Name _____ Relationship _____
 Address _____
 Telephone: home _____ work: _____ cell _____

Name _____ Relationship _____
 Address _____
 Telephone: home _____ work: _____ cell _____

CONSENT FOR TREATMENT

My signature below indicates that:

- I consent to medical and nursing treatment by the Middlebury College Health Services staff.
- The information on this form is correct and complete to the best of my knowledge.
- I understand that Middlebury College views my health as chiefly my responsibility.
- If I require services, prescriptions, or referrals beyond the primary care services available at Middlebury College Health Service, I shall assume the financial responsibility or negotiate satisfactory arrangements with the caregiver.
- I understand that my contacts with health services are held in confidence, but that confidentiality may be broken if my life or that of another person is in danger.

Signature of student _____ Date _____

Signature of parent/guardian _____ Date _____

(Required if student is not yet 18 years old)