HastingsCollege™

Stone Health Center

Student Information Form

Date____________________

Last Name (Please Print)__________________________ **First**__________________________ **Middle**________________

Nickname (I prefer to be called)____

Cell Phone Number ______________________________ **Date of Birth**____________________________

Home Address____
Street City State/Zip

Emergency Contact Information:

Parent(s), Legal Guardian(s) or Spouse's full name(s)____

Parent(s), Legal Guardian(s) or Spouse's address____
Street City State/Zip

Phone Numbers: Home (______) ________________________ **Cell (______)** ____________________________

Email address(s) ____

Other emergency contact information ____
Name

_______________________________________ **Phone Number (_______)** _____________________________
Relationship

Health History:

Personal History

Tobacco use, inc. smokeless	[ ]	____________
Alcohol use, frequency, quantity	[ ]	____________
Seatbelts…check if always used	[ ]	____________
Exercise…type, frequency	[ ]	____________
Special Diet	[ ]	____________

Surgical Operations	Date
____________________________	____________
____________________________	____________

Injuries (Serious)	Date
____________________________	____________
____________________________	____________

Current Medications	Dosage
____________________________	____________
____________________________	____________
____________________________	____________
____________________________	____________

Allergies	Date
Food________________________	____________
____________________________	____________
____________________________	____________
Drug Sensitivities or Allergies	
____________________________	____________
____________________________	____________
Other_______________________	____________
____________________________	____________

Previous Illnesses	√	**Date, if known**	**Type**
Anorexia/Bulimia	[ ]	____________	
Asthma	[ ]	____________	
Cancer/Type	[ ]	____________	__________
Colon Disease	[ ]	____________	
Diabetes	[ ]	____________	
Gynecological Problems	[ ]	____________	
Hay Fever	[ ]	____________	
Heart Disease/Murmur	[ ]	____________	
Hepatitis/Type	[ ]	____________	__________
High Blood Pressure	[ ]	____________	
Kidney Diseases/Stones	[ ]	____________	
Migraines	[ ]	____________	
Mononucleosis	[ ]	____________	
Orthopedic/Type	[ ]	____________	__________
Phlebitis/Deep Vein Clot	[ ]	____________	
Pneumonia	[ ]	____________	
Seizure Disorder/Type	[ ]	____________	__________
Sickle Cell Disease/Trait	[ ]	____________	
Sinusitis	[ ]	____________	
Skin Trouble/Type	[ ]	____________	__________
TB Test, Positive	[ ]	____________	
Thyroid Disease	[ ]	____________	
Ulcer	[ ]	____________	
Other	[ ]	____________	

Special Additional History (Emotional or Physical): ____
____
____