Rivier UNIVERSITY

# Student Health Record

## Student - FORM B

## REPORT OF HEALTH HISTORY

*Required for resident students ONLY*

**Name**_____ **DOB**: _____
Last First Middle

**Home Address** _____
*Number/Street/Apartment#* *City* *State* *Zip code*

**Marital Status**: Single Married Other **Home Phone**: (_____)_____

**Gender at Birth**: Male Female **Student cell phone number** (_____)_____

**Primary Care Physician** _____ **Phone** ( _____) _____

**Physician Address** _____ **Fax** (_____) _____

***Emergency Contact*** _____ **Phone** ( _____) _____

***Relation to Student*** _____ ***Secondary Phone*** (_____) _____

### FAMILY HISTORY/INFORMATION

Father's Name _____ *Primary phone* (_____)_____
Father's Home Address _____ *Secondary phone* (_____)_____
City/State/Zip_____

Mother's Name _____ *Primary phone* (_____) _____
Mother's Home Address _____ *Secondary phone* (_____) _____
City/State/Zip_____

Additional Contact Numbers *Phones*_____ *Pagers*_____

| Relation | Age | State of Health | Occupation | Age at Death | Cause of Death |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Brother | | | | | |
| Brother | | | | | |
| Sister | | | | | |
| Sister | | | | | |



Return this form by August 15 to: Quibin Student Health Services,
Guild Hall, Rivier University, 420 South Main St., Nashua, NH 03060-5086. *Fax: (603) 897-8806.*

**Family History**: Have any of your blood relatives had any of the following? ___*check here if unknown*

| | Y | N | Relationship | | Y | N | Relationship |
|---|---|---|---|---|---|---|---|
| Alcoholism | | | | Headaches | | | |
| Allergies | | | | Heart Disease | | | |
| Arthritis | | | | High Blood Pressure | | | |
| Asthma | | | | Kidney Disease | | | |
| Cholesterol Problems | | | | Intestinal/stomach Problems | | | |
| Cancer | | | | Lung Disease | | | |
| Depression | | | | Stroke | | | |
| Diabetes | | | | Other: | | | |
| Epilepsy/Convulsions | | | | Other: | | | |

**Medical History**: Have you had any of the following problems?

| | Y | N | | Y | N | | Y | N |
|---|---|---|---|---|---|---|---|---|
| Alcoholism | | | Fainting/Blackouts | | | Rheumatic Fever | | |
| Allergies | | | Hay fever | | | Scarlet Fever | | |
| Anemia | | | Head Injury | | | Sexually Transmitted disease | | |
| Anxiety Disorder | | | Unconsciousness | | | Shortness of Breath | | |
| Anorexia Nervosa | | | Headaches | | | Sinus Trouble | | |
| Arthritis | | | Hearing Loss | | | Skin Problems | | |
| Asthma | | | Heart Murmur | | | Strep Throat, frequent | | |
| Back Problems | | | Hemorrhoids | | | Substance Abuse | | |
| Bleeding Problems | | | Hepatitis | | | Thyroid Disease | | |
| Broken Bones | | | Jaundice | | | Lung Disease | | |
| Bulimia Nervosa | | | Hernia | | | Tumors | | |
| Cancer | | | High Blood Pressure | | | Typhoid Fever | | |
| Chicken Pox | | | Indigestion, frequent | | | Underweight | | |
| Cholesterol Problems | | | Insomnia | | | Urinary Tract Infections, frequent | | |
| Chronic Cough | | | Intestinal/stomach problems or ulcers | | | Varicose Veins | | |
| Chronic Constipation | | | Kidney Disease | | | Unexplained recent weight gain/lose | | |
| Colds, Recurrent | | | Leukemia | | | Eye Trouble | | |
| Colitis | | | Low Blood Pressure | | | Muscle weakness/paralysis | | |
| Dental Problems | | | Malaria | | | Overweight | | |
| Depression | | | German Measles | | | Heart Palpitations | | |
| Diabetes | | | Measles (Rubeola) | | | Pneumonia | | |
| Diarrhea, frequent | | | Mononucleosis | | | Polio | | |
| Diphtheria | | | Mumps | | | Pregnancy | | |
| Dizziness | | | Fainting/Blackouts | | | Other | | |
| Ear Trouble | | | Foot Problems | | | | | |
| Epilepsy | | | | | | | | |

Comments regarding "yes" to any of the above questions_____

_____

_____

| ***Allergies** | Y | N | **Past medical and surgical history:** | Y | N | ***For women only:*** | Y | N |
|---|---|---|---|---|---|---|---|---|
| Penicillin medications | | | Appendectomy | | | Birth control pills | | |
| Sulfa medications | | | Tonsillectomy | | | Severe Menstrual Cramps/Heavy Periods | | |
| Chicken/Feathers/Eggs | | | Other surgery: *list* | | | Irregular periods | | |
| Food (list: ) | | | Other surgery: *list* | | | Breast lumps | | |
| Nuts | | | Hernia repair | | | Other: | | |
| Pineapple or other fruit | | | Special Needs | | | Other: | | |
| Bees/Wasps/other insects | | | Cancer | | | | | |
| Latex | | | Sexually Transmitted Disease | | | | | |
| Pollen/Dust /Mold | | | Anorexia/Bulimia/other eating differences | | | | | |
| Other: | | | Anxiety or Depression | | | | | |



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The following information is required of every resident student, regardless of college athletic participation.

***Please speak with student's health care provider regarding need for EpiPen for allergic responses***

***Please describe allergic response symptoms**_____

Please list any current prescription and non-prescription **medications** that you take: ***Include any herbal and sports-related supplements.***

| Name | Dose (mg) | Frequency | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**History of Injuries:** **Check here if student has had NO injuries_____**

| | Date | Surgery? | Residual Problems? |
|---|---|---|---|
| Head Injury | | | |
| Concussion | | | |
| Loss of consciousness | | | |
| Broken bones | | | |
| neck/shoulder | | | |
| Arm/elbow/wrist/hand | | | |
| Back | | | |
| Hips | | | |
| Leg | | | |
| Ankle, foot | | | |

**ADDITIONAL INFORMATION:**

When was your last visit to a dentist?_____

If you smoke, how many cigarettes a day and number of years?_____ _____

How much caffeine to you consume? (coffee/tea/soda). Number per day_____ _____

If you drink alcoholic beverages – How many in a day or week? _____per day _____per week.

Do you use street drugs? _____

Are you on a diet?_____ _____

Have you ever been in a hospital overnight? _____ If yes, *explain*_____ _____

Have you ever received mental health services or hospitalized for mental health reasons? _____

If yes, *explain*_____ _____

Are you interested in counseling services while you are living on campus? _____Yes _____No

Are you now, or have you ever been treated for an eating disorder? List date(s) of care._____

Have you experienced the loss of a parent? _____ *If yes, please provide information:*

___*mother* _____*father* *Date of loss:*_____

Do you have any questions about your health or other matters that you would like to discuss with a member of Health Services?

___yes ___no *If yes, please list your primary telephone number and best time for us to call*_____

Will you be restricted from physical activity or sports participation? _____

If yes, please make sure your health care provider submits to us details of restriction.

***I give permission for my immunization and physical exam data to be shared with Athletics, if I elect to participate in sports at Rivier University.***

***I understand that all non-refrigerated medications should be kept in a secure, locked metal box while I am living on campus with exception of medications that needed to be carried with me such as inhalers or epi pens, etc.***

*Failure to submit health forms by this time may result in a delay in admittance to the Residence Hall on campus.*

I hereby certify that the above information is accurate and correct to the best of my knowledge.

Student Signature _____ Date_____

Parent/Legal Guardian Signature _____ Date _____

(if student under 18)



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