Health Questionnaire Form – to be completed by student

IOWA WESLEYAN UNIVERSITY 1842

*Name*__________________________ *Sex*______ *Age*______ *Date of birth*____________________________

*Year in College*______________________________ *Allergies* ____

*Home Address*____

*Personal Health Care Provider*____

*Address*____ *Telephone #* _______________________________________

Current Medications ____

In Case of Emergency contact:

*Name*____________________________________ *Relationship*______________ *Phone (C)* ____________*(H)* ___________ *(W)* __________

Address ____

NOTE: These records are confidential and are part of your health records at IW. They will not be shared with non-clinic staff or faculty.

Any "Yes" answers, please explain in the following section:
Circle questions if you do not know the answer.

Question	Yes	No
1. Do you have an ongoing medical condition (diabetes, asthma, high blood pressure, heart murmur, etc.)?		
2. Are you currently taking any prescription or nonprescription (over-the-counter) medication or pills including an inhaler or asthma medicine?		
3. Do you have allergies to medicines, pollens, foods, or stinging insects?		
4. Have you ever had surgery?		
5. Do you regularly use a brace or assistive device?		
6. Is there anyone in your family who has asthma?		
7. Were you born without or are you missing a kidney, eye, testicle, or any other organ?		
8. Have you had infectious mononucleosis (mono) within the last month?		
9. Have you ever had a head injury, concussion, been confused or lost your memory?		
10. Have you ever had a seizure?		
11. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?		
12. Have you ever been unable to move your arms or legs after being hit or falling?		
13. Has your health care provider told you that you or someone in your family has sickle cell trait or sickle cell disease?		
14. Have you had any problems with your eyes or vision?		
15. Do you wear glasses or contact lenses?		
16. Are you happy with your weight?		
17. Are you trying to gain or lose weight?		
18. Have you ever had a herpes skin infection?		

Question	Yes	No
19. Has anyone recommended you change your weight or eating habits?		
20. Do you limit or carefully control what you eat?		
21. Do you have any concerns you would like to discuss with a health care provider?		
22. Has a health care provider ever ordered a test for your heart? (example ECG or echocardiogram)		
23. Has anyone in your family died for no apparent reason?		
24. Does anyone in your family have a heart problem?		
25. Has any family member or relative died of health problems or sudden death before age 50?		
26. Does anyone in your family have Marfan Syndrome?		
27. Have you ever spent the night in a hospital?		
28. Has a health care provider ever denied or restricted your participation in sports for any reason?		
29. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
30. When exercising in the heat, do you have severe muscle cramps or become ill?		
31. Have you ever had discomfort, pain, or pressure in your chest during exercise?		
32. Does your heart race or skip beats during exercise?		
33. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
34. Have you ever had a stress fracture?		
35. Have you been told you have or have had an x-ray for atlantoaxial (neck) instability?		
36. Do you wear protective eyewear, such as goggles or face shield?		

Yes No

38. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis that caused you to miss a practice or game? If so, circle affected area in the box below.
39. Have you had any broken or fractured bones or dislocated joints? If yes, circle where in the box below.
40. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle where in the box below. If other, please list.

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm
Hand/Finger	Chest	Upper Back	Hip	Thigh	Knee
Calf/Shin	Ankle	Foot/Toes			

41. How old were you when you had your first menstrual period? ______
42. Are your periods regular? Yes / No
43. How many periods have you had in the last 12 months? ______

MENTAL HEALTH QUESTIONS

44. Have you ever experienced the following: Yes No
    - Depression?
    - Anxiety?
    - Self-harming behavior ?
    - Suicidal thoughts?
    - ADHD?
    - Eating disorder?
    - Other mental health disorder?

45. Have you ever been hospitalized a mental health disorder? Yes No
46. Have you ever received treatment for alcohol or substance use?
47. Have you struggled with alcohol or substance use?
48. Would you like to be connected to a counselor when you arrive on campus?

EXPLAIN ALL "YES" ANSWERS HERE.

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student ____Date ______________

Printed Name of Parent/ Legal Guardian ____

Signature of Parent/ Legal Guardian ____________________________________Date ______________
(If student under the age of 18)

Upload this completed form along with your immunization documentation to Med+Proctor. Instructions included in this packet.