GUTENBERG COLLEGE • 1883 UNIVERSITY STREET • EUGENE, OREGON 97403

HEALTH HISTORY (CONFIDENTIAL)

Please complete this form and return it to the Gutenberg office before the first day of classes. The information submitted will be treated confidentially and is within the mandates of the Federal Educational Rights and Privacy Act (FERPA).

Please print.

Name: Last ____ First ____ M.I. ____ Sex ☐ M ☐ F

Age ____ DOB (month/day/year) ____ Height ____ feet ____ inches ____ Weight ____ lbs.

Place of Birth: City ____ State ____ Country ____

Are you allergic to any medications? Yes ☐ No ☐
If yes, please list medication and the reaction you had to it:

Are you currently taking any medications? Yes ☐ No ☐
If yes, list medication and dosage (please include regularly taken nonprescription drugs, vitamins, diet aids, etc.):

Do you have any allergies? Yes ☐ No ☐
If yes, please list:

Immunizations

Please list dates of immunizations. **This information is required.**

Tetanus ____ Small Pox ____ Typhoid ____

DPT ____ Polio ____ Influenza ____

(See other side.)

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Past Illness History

Please check box if you have ever been diagnosed with any of the following illnesses. **This information is required.**

☐ Measles	☐ Thyroid Disease	☐ Arthritis	☐ Rheumatic Fever
☐ Liver Disease	☐ Lung Disease	☐ Gout	☐ Diabetes/Hypoglycemia
☐ Hepatitis	☐ Pneumonia	☐ Vision Disorder	☐ Epilepsy
☐ Cancer	☐ Gastric Ulcers	☐ Migraine Headaches	☐ Asthma/Hay Fever
☐ Anemia	☐ Anorexia/Bulimia	☐ Kidney Disease	☐ Asthma/Hay Fever
☐ Broken Bones	☐ Head Injury	☐ Congenital Deformity	☐ High Blood Pressure
☐ Chemical	☐ Addiction	☐ Other: ______________________	

Are you currently under a physician's care? Yes ☐ No ☐
If yes, please describe condition:

____

____

Have you or are you under the care of a counselor or a psychiatrist? Yes ☐ No ☐
If yes, please describe condition and dates of therapy:

____

____

Have you ever been hospitalized or had surgery? Yes ☐ No ☐
If yes, list date and condition:

____

____

Physician's name and telephone number:

Dr. ______________________________ (   ) ______________________

The information given on this Health History form is accurate to the best of my knowledge. I understand this information is confidential and cannot be released without my written consent.

Signature ______________________________ **Date** ______________________