CONFIDENTIAL

CABRINI COLLEGE STUDENT HEALTH CENTER
Health History/Contact Sheet

610 King of Prussia Road • Radnor, PA 19087 - Phone (610 902-8531 • Fax: (610) 902-8282

Please make two additional copies of all forms: One for your records at home and one for participation in intramural or club sports activities.

Name: ____
Last *First* *Middle*

Soc. Sec. # _______-________-___________ Date of Birth_____/_____/________ Gender: ___________________________

College entrance Date: (mo/yr) _______/______________ Class (please circle): Fr So Jr Sr

Resident or Commuter? ____ Cabrini ID# ______________________________

Home Address: ____
Number and street *City* *State* *Zip*

Home phone # _________/_________/_______________ Cell phone #: _________/________/__________________

Student's preferred email: ____

Parents' email/s: (optional) ____

Please list up to 3 people whom we can contact in case of emergency: (in order of preference)

Name	Relationship	Work phone	Cell phone
1			
2			
3			

Family History:

Relationship	Age	Occupation	Health Problems?
Mother			
Father			
Sibling			
Sibling			

Are you allergic to any medications/foods or have you had any bad reactions?

Medication/food **Type of reaction (e.g.,anaphylaxis, lip/tongue swelling, hives, rash, shortness of breath)**

_________________________ ____

_________________________ ____

_________________________ ____

List any medications you are currently taking, with dosages:

________________________________ ________________________________ ________________________

________________________________ ________________________________ ________________________

If there is anything else we need to know about your health, please have your health care provider forward to us any copies of records that will help us care for you.

Name: ______________________________ **Soc. Sec. #:** ____________________

Please list any major surgeries or hospitalizations you have had.

Surgery/Condition/Hospitalization	Date	Surgery/Condition/Hospitalization	Date

Do you use alcohol? Yes _____ No ____ How often? ________________________ How much? ________________________
Have you ever used injection drugs? ____
If you are a former smoker, when did you quit? ______ How long did you smoke? ________How many packs a day?___________
Have you had traumatic events in your life, either physical or emotional?____
____

Have you ever had or have you ever been diagnosed with the following? (Please check all that apply

	Allergy to latex		High Blood Pressure		Cancer (specify):
	Anemia		High Cholesterol		
	Anorexia Nervosa		HIV Infection		
	Anxiety Disorder		Inflammatory bowel disease		Food allergy, serious (specify):
	Arthritis		Colitis		
	Asthma		Crohn's disease		
	Attention deficit disorder		Learning disability		Heart/vascular problems:
	Bleeding disorder		Loss of consciousness		Aneurysm
	Blood clots, deep vein		Malaria		Angina
	Bulimia		Menstrual problems		Congestive heart failure
	Chicken pox		Migraine		Heart Attack
	Chronic fatigue syndrome		Mononucleosis		Stroke
	Chronic lung disease		Overweight/obesity		Kidney disease
	Concussion		Parasitic disease		STD (specify):
	Depression		Pelvic Inflammatory disease		
	Diabetes Mellitus		Prostatitis		
	Eating disorder		Repetitive stress injury		Skin problems, current (specify):
	Endometriosis		Seizure		
	Hay fever/allergic rhinitis		Smoker, packs per day _____		
	Head injury, serious		Tuberculosis		Sleep disorder/ insomnia
	Headaches, severe, non-migraine		Broken bones, (specify):		Thyroid disorder
	Heart murmur				Tuberculosis exposure
	Hepatitis B		Eye problems, serious (specify):		Treatment:
	Hepatitis C				Weight gain or loss, recent

Use this space to provide more details about anything you have checked off above:

INSURANCE INFORMATION

I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at Cabrini College.
I am currently covered under the following health insurance policy:

Insurance Company Name: ____Policy # __________________________________

Group # (if applicable) _______________________________Policy Holder Name: ____

Are referrals required? ________Primary Care Physician:______________________________Physician's phone # _______________________

Though the Student Health Center does not bill insurance companies, in order to better care for each student we ask that you send front and back copies of insurance and prescription cards in case of lab work, referrals, or emergency.