

CORNERSTONE UNIVERSITY HEALTH SERVICES
HEALTH HISTORY

All new students are **required** to complete and return this form.
 It may be submitted online, by mail, or by fax. See contact information at page bottom.

GENERAL INFORMATION:

Last Name (Print), First, Middle	Date of Birth	Cornerstone ID #
Home Street Address	Student Status: F S J S Grad.	Year Entering Cornerstone
Home City, State, Country, Zip/Postal Code	Sex: M F	Marital Status: S M D W
E-mail Address and Cell Phone	Height	Weight

PARENT or GUARDIAN CONTACT INFORMATION:

Last Name (Print), First, Middle	Relationship	Home Phone
Home Street Address, City, State, Country, Zip/Postal Code		Work Phone
Alternate Address	E-mail Address	Cell Phone

ALTERNATIVE EMERGENCY CONTACT INFORMATION (local or nearest Cornerstone, if you have one):

Last Name (Print), First, Middle	Relationship	Home Phone
Home Street Address, City, State, Country, Zip/Postal Code		Work Phone
Alternate Address	E-mail Address	Cell Phone

PERSONAL HEALTH HISTORY: Please answer the following and provide pertinent information:

- I have been treated by a health care provider or therapist for a health concern. Please list:
- I am taking prescription medications regularly. Please list:
- Hospitalizations/Surgeries: Please list, with dates:
- Food or drug allergies: Please list:
- I have received services for a disability. Please list:

Select any of the physical or mental problems you currently have or have ever had. Please enter the dates you had them.

<input type="checkbox"/>	ADHD	<input type="checkbox"/>	Heart Problems
<input type="checkbox"/>	Allergy injections	<input type="checkbox"/>	Hepatitis/ Liver Disease
<input type="checkbox"/>	Anxiety and/or depression	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Kidney/Urinary Problems
<input type="checkbox"/>	Bipolar Disorder	<input type="checkbox"/>	Neurological Problem or Seizures
<input type="checkbox"/>	Bone/Joint Problems	<input type="checkbox"/>	Skin Problem
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Sleep Disorder
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Thyroid Disorder
<input type="checkbox"/>	Eating Disorder/Low Weight	<input type="checkbox"/>	Vision(other than corrective lenses)/Hearing
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Other/Not Listed