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.

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