Saint Mary's University OF MINNESOTA

STUDENT HEALTH HISTORY FORM

STUDENT HEALTH SERVICES
700 TERRACE HEIGHTS #81
WINONA, MN 55987-1399 USA
PHONE 507-457-1492
FAX 507-457-6920

ALL new, transfer, and readmitted students are required to complete and return this form to Student Health Services prior to the start of your first semester.

Name: Date of Birth:

Cell Phone: Home Phone:

Home Address:

City, State, Zip:

Have you attended SMU in the past? ☐ Yes* ☐ No *If yes, what years:

Are you an International Student? ☐ Yes* ☐ No *If yes, country of citizenship:

POLICY OF CONFIDENTIALITY: This information is confidential and will not be shared with any person or office outside of the offices of Student Health or Counseling in the Jay Johnson Wellness Center without your written consent. Counseling and Student Health professionals will consult with each other regarding your physical, mental or emotional health when needed to effectively assist you with your health needs. Additionally, Student Health may consult with the athletic training staff if you are an intercollegiate athlete.
EXCEPTIONS TO THE POLICY OF CONFIDENTIALITY: For referral or treatment to other care providers such as physicians, nurses and therapists, for health oversight activities authorized by law; to public health authorities with information on communicable diseases and vital records; to law enforcement when required by law, including mandatory abuse reporting; and to appropriate individuals when we believe it necessary to avoid a serious threat to health or safety or to prevent serious harm to the individual.

I have read and understand the above policy.

Student Signature Date

HEALTH INSURANCE

☐ I do not have insurance. ☐ I do have insurance. (Please attach a copy, front and back, of your insurance card.)

If you are under 18, it is necessary for your parent or guardian to complete the following:
I give permission for my son/daughter to receive health and/or counseling services at the Saint Mary's University Wellness Center.

Parent or Guardian Signature Date

PARENTAL INFORMATION

Living with: ☐ Mother ☐ Father ☐ Both ☐ Other:

Mother/Guardian Name:	Father/Guardian Name:
Home/Cell Phone:	Home/Cell Phone:
Address:	Address:
City, State, Zip:	City, State, Zip:
Country:	Country:

FAMILY HEALTH STATUS

Parents Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Remarried

	Age	Occupation	Living	Deceased	Cause of Death	Year of Death
Mother						
Father						
Brothers						
Sisters						

REQUIRED VACCINATIONS

Minnesota law requires the month and year of the following vaccinations to maintain enrollment.

Please list **MONTH / YEAR** for each vaccination:

MMR #1 _____ /_____

MMR #2 _____ /_____

Tetanus _____ /_____ (within last 10 years) ☐ Td or ☐ Tdap?

RECOMMENDED VACCINATIONS

Hepatitis A #1 ____ /____ #2 ____ /____

Hepatitis B #1 ____ /____ #2 ____ /____ #3 ____ /____

Varicella #1 ____ /____ #2 ____ /____
OR had the illness ____ /____

HPV #1 ____ /____ #2 ____ /____ #3 ____ /____

Meningitis B #1 ____ /____ #2 ____ /____

Influenza (yearly) ____ /____ (most recent dose)

ALLERGIES

☐ I do not have any allergies.

☐ Medication allergies:

☐ Food allergiess:

☐ Other allergies:

Please describe your specific reaction to any allergies noted above:

Do you carry an epi-pen? ☐ Yes ☐ No

PERSONAL HEALTH HISTORY

Do you have a history of any of the following:

Eye or vision problems (other than corrective lenses)	☐ Yes ☐ No	Head injury with unconsciousness	☐ Yes ☐ No
Ear, nose, throat or mouth problems	☐ Yes ☐ No	Disease or injury of the joints	☐ Yes ☐ No
Hay fever	☐ Yes ☐ No	Back problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Sleep issues	☐ Yes ☐ No
Heart or cardiovascular conditions	☐ Yes ☐ No	ADD/ADHD	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Anxiety or panic attacks	☐ Yes ☐ No
Thyroid conditions	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Anemia or other blood disorders	☐ Yes ☐ No	Eating disorders	☐ Yes ☐ No
Stomach or intestinal problems	☐ Yes ☐ No	Chemical/alcohol dependency	☐ Yes ☐ No
Urinary problems	☐ Yes ☐ No	Tobacco use	☐ Yes ☐ No
Menstrual problems	☐ Yes ☐ No	Other	☐ Yes ☐ No
Frequent headaches or migraine	☐ Yes ☐ No	Please explain any “yes” answers:	
Dizziness or fainting episodes	☐ Yes ☐ No		
Epilepsy	☐ Yes ☐ No		
Concussion	☐ Yes ☐ No		

MEDICATIONS (prescription and over-the-counter):

Medication	Dose	Frequency

SURGERIES OR HOSPITALIZATIONS: (include dates)

If you have a chronic condition (i.e. asthma, diabetes, epilepsy, mental health condition) or significant health history:

1. You are strongly encouraged to visit your healthcare provider within the 6 months prior to beginning at Saint Mary’s University.
2. Please describe your plan for management of this condition during your time at Saint Mary’s University: (i.e. will you continue to follow-up with your healthcare provider? Do you anticipate utilizing health or counseling services on campus for management?)