**Health History-Brooks Health & Wellness Center**

**COMPLETE AND RETURN TO**

Brooks Health & Wellness Center

300 College Street NE; Post Office Box 7178

Orangeburg, South Carolina 29117

**Telephone**: 803-536-7053/7055

**Fax number:** 803-533-3747

**Email:** [**BHC@scsu.edu**](mailto:BHC@scsu.edu)

**South Carolina State University**

**Semester of Enrollment:  Fall  Spring Summer**

**Year: Click Here**

**PLEASE RETURN BY: AUGUST 1 (FALL) DECEMBER 1 (SPRING)**

**Enrollment Status:**

Freshman Transfer

**“WHERE GOOD HEALTH COMES FIRST”**

Graduate  Online

Returning  Readmit

**Female  Male Other**

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| --- | --- | --- | --- | --- | --- |
| **Last Name:** | Click or tap here to enter text. | **First Name:** | **Click or tap here to enter text.** | **MI:** | Click or tap here to enter text. |

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| --- | --- | --- | --- |
| **Date of Birth:** | Click or tap here to enter text | **Student ID#:** | Click or tap here to enter text. |

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| **University Email:** | Click or tap here to enter text. | **Cell/Home Phone**: | Click or tap here to enter text. |

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| --- | --- |
| **Permanent Address:** | Click or tap here to enter text. |

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| --- | --- | --- | --- | --- | --- |
| **City:** | Click or tap here to enter text. | **State:** | Click or tap here to enter text. | **Zip:** | Click or tap here to enter text. |

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| **Parent/Guardian:** | **Click or tap here to enter text.** | **Cell/Home Phone:** | Click or tap here to enter text. |

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| **Emergency Contact:** | Click or tap here to enter text. | **Phone#:** | Click or tap here to enter text. | **Work#:** | Click or tap here to enter text. |

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| **Health Ins/Policy Holder:** | **Click or tap here to enter text.** | **Policy#** | Click or tap here to enter text. |

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| **Insurance Company Address/Phone:**Click or tap here to enter text. |

The following health history is ***CONFIDENTIAL***, does not affect your admission status and, except in an emergency or by court order, will not be released without your written permission.

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| **N=Normal or X= Abnormal (Explain)** | **Student** | **Family** | **Comments/Explanations** |
| Cardiovascular/Heart | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Hypertension | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Stroke | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Diabetes | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Arthritis | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Lung (+) TB Test/Chest X-ray/Chronic Bronchitis  **Asthma** | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Kidney/Recurrent Urinary Problems | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Gastrointestinal | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Liver | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Neurological | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Emotional or Mental Illness/ Retardation | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Surgery/Hospital/Emergency Room | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| OB/GYN: Date of last Menstrual Period | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Vision Loss/Eye Disease | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Migraines/Vascular Headaches | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Sinusitis | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Anemia/SSD/SC/Thal/Traits | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Cancer/Immunodeficiency Disorder | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Rheumatic Fever | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Seizures/Convulsions | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Accidents/Injuries | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Drug/Alcohol/Tobacco Use/Abuse | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Allergies: Food, Medications, Dust, etc.** | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| STD’s/GC, Chlamydia, NGU, other | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Dental Caries, Gum Disease | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Eating Disorder | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Other/Explain | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
|  | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

**MEDICATIONS:**

**Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural products (prescription and nonprescription) you use and how often you use them**.

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| **Name:** | Click or tap here to enter text. | **Use:** | Click or tap here to enter text. | **Dosage:** | Click or tap here to enter text. |
| **Name:** | Click or tap here to enter text. | **Use:** | Click or tap here to enter text. | **Dosage:** | Click or tap here to enter text. |
| **Name:** | Click or tap here to enter text. | **Use:** | Click or tap here to enter text. | **Dosage:** | Click or tap here to enter text. |
| **Name:** | Click or tap here to enter text. | **Use:** | Click or tap here to enter text. | **Dosage:** | Click or tap here to enter text. |

**IMPORTANT INFORMATION......PLEASE READ AND COMPLETE**

**STATEMENT BY STUDENT (OR PARENT/GUARDIAN, IF STUDENT UNDER AGE 18)**

* I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill/injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the SC State University representative to release information from my (son/daughter’s) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.
* I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physician/nurse practitioner/physician assistant/nurses at Brooks Health Center.
* I am aware that the Brooks Health Center charges for some services, which are payable through the University’s Cashier’s/ Bursar’s Office. I accept personal responsibility for payment of incurred charges. I am responsible for filing outpatient charges with my insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage.

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| **E-Signature of Student:** | Click or tap here to enter text. | | **Date:** | Click or tap here to enter text. |
| **E-Signature Parent/Guardian:** | | Click or tap here to enter text. | **Date:** | Click or tap here to enter text. |

**If student is under age 18**

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| **Brooks Health & Wellness Center Staff Only:** |
| **Received by:**Click or tap here to enter text. | | **Date:**Click or tap here to enter text. |

4/18,4/21,5/53,12/23