



For Office Use Only:
Imm. Record: Complete / Incomplete
Reviewed: _____
Entered: _____

(Please return to Wellness Center before July 15 for fall semester enrollment and Dec.1 for spring semester enrollment)

Name: _____ **Date of Birth:** ____ / ____ / ____ **Sex:** M F **Student ID#:** _____ *(If current student)*
(Last / First / Middle) Month/Day/Year

Permanent Address: _____ **Phone Number:** _____
(Street/Apartment Number) Country: _____
(City/State/ZIP)

Local Address: _____ **Phone Number:** _____
(Street/Apartment Number) Country: _____

Parent / Guardian: _____ (Name) _____ (Relationship) _____ (Home Phone) _____ (Work Phone)

In case of emergency, notify: _____ Phone: _____ Relationship _____

YOUR CURRENT EMAIL ADDRESS: _____ Ethnic/cultural identity: Latino/a Caucasian-European
 African American East Asian South Asian Other _____ International Students: Country of Origin _____

Semester and year of enrollment: Fall ____ Spring ____ Summer ____

Class Standing: FR / SO / JR / SR / 5th / Graduate Student ____ (year) **Will you be attending:** Full-time Part time

Attach a copy of your Health Insurance: Private / Family Insurance Student Insurance No Insurance Other _____

Have you previously attended Dominican University? No Yes - If yes, please indicate year (s) _____

Are you an DU athlete? No Yes - If yes, please indicate which sport(s): _____

Have you had: *

	NO	YES		NO	YES		NO	YES
Allergies (seasonal)			Respiratory Problems			Low Blood pressure		
Head Injury			Tuberculosis			Heat related illness (exhaustion stroke)		
Dizziness/fainting			Gastrointestinal problems			Hernia (Kidney / Urinary problems)		
Dizziness/fainting with exertion			Blood Disorders			Anemia		
Headaches (migraines)			Recent weight changes			Cancer		
Seizure disorder			Gallbladder problems			Chicken pox		
Meningitis			Stomach ulcers			Fracture/Sprain		
Ear problems (hearing Loss)			Diabetes mellitus(Type I/II)			Back problems		
Eye problems			Low Blood Sugar			Marfan's Syndrome		
Sinus problems			Liver Disease			Eating Disorders		
Strep throat (recurrent)			Hepatitis A,B,C			Counseling/mental health treatment		
Thyroid problems			Mononucleosis			Depression		
Frequent colds			Heart murmur			Anxiety		
Asthma (chronic)			Heart arrhythmia			Sickle Cell Trait		
Asthma(exercise induced)			Heart disease			Arthritis		
			Rheumatic fever					
			High blood pressure					

Orthopedic Injuries: *

	NO	YES		NO	YES
Ankle		R L	Elbow		
Shin Splints		R L	Wrist/hand		R L
Knee		R L	Neck		R L
Hip		R L	Head		R L
Back			Concussion/loss of consciousness		
Shoulder					

*Please explain all answers marked with YES: add a page if needed.

1. Do you have any allergies? (medications, foods, environmental, insect bites / stings, latex, nuts):

Allergen	Reaction

2. Are you currently under the supervision of a physician? No Yes (please explain below)

If yes, please explain: _____

3. Do you exercise? Yes No How? _____ Frequency? _____

4. Do you smoke or use tobacco? Yes No How much? _____ How often? _____

5. Are you currently taking any medications? No Yes (please list below)

Please include medications taken on a regular or as-needed basis along with any vitamins, herbal or nutritional supplements.

Medication (name, dose, frequency)*	Reason

*If you administer injectable prescription medications, contact the Wellness Center to receive information on disposal of syringes and needles.

6. Have you ever been hospitalized (injury or illness) or had any surgical procedures? No Yes (please list below)

Reason	Dates

7. Have you ever been diagnosed with a stress fracture? No Yes (please provide details below)

Location	Date

8. Do you have a family history of the following?

Disease	No	Yes	If yes, please indicate relationship
Diabetes			
Cancer			
Heart Disease			
Hypertension			
Tuberculosis			
Stroke			

*Has any member of your family died suddenly before the age of 40 from a non-traumatic cause?

No Yes - If yes, please explain how : _____

9. Please complete the appropriate section:

For Women	For Men
Onset first menstrual period (age):	Testicular conditions <input type="checkbox"/> No <input type="checkbox"/> Yes
Abnormal flow? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Explain:	Prostate conditions <input type="checkbox"/> No <input type="checkbox"/> Yes
Excessive/sever cramping? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Pregnant now or within past year? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Date of last pelvic exam:	Explain:

10. Is there anything we should know about your health that we have not asked yet? No Yes

If yes, please explain: _____

I HEREBY CERTIFY THAT THE ABOVE QUESTIONS ARE ANSWERED TO THE BEST OF MY KNOWLEDGE. _____

Student Signature: _____

Date: _____