MARANATHA
BAPTIST UNIVERSITY

MEDICAL HISTORY

A medical history is required for all incoming main campus students.
This report should be filled out by the incoming student.
Return all completed forms to MBU Admissions.

Last Name	First Name	Middle Name	Date of Birth (mm/dd/yyyy)

Address	City	State	Zip

Telephone (Please indicate if home or personal cell #)	Gender	Marital Status
( ) - ☐ Home ☐ Cell	☐ M ☐ F	☐ Single ☐ Married

1. When do you plan to enroll at the Watertown campus? Year ___________ Fall ______ Spring ______
   If you are a former main campus Maranatha student, enter last semester you attended: Year __________ Fall______ Spring_____
2. Do you plan to participate in intercollegiate athletics? Yes _____ No _____
3. Do you plan to enroll in the nursing program? Yes _____ No _____

FAMILY HEALTH HISTORY

Has any person related to you by blood had any of the following?

	Y	N	Relationship		Y	N	Relationship		Y	N	Relationship
Stroke/High Blood Pressure				Cholesterol/Blood fat disorder				Alcohol/drug problems			
Cancer (type)				Diabetes				Psychiatric illness			
Heart attack before age 55				Blood or clotting disorder				Suicide			

A. Is either parent deceased? Yes _____ No _____ If yes, cause of death: ______________________________

B. Are any siblings deceased? Yes _____ No _____ If yes, cause of death: ______________________________

PERSONAL HEALTH HISTORY

Have you ever had or do you have any of the following? (Please check each item and explain any "yes" answers on separate sheet of paper.)

	Y	N		Y	N		Y	N		Y	N
High blood pressure			Mononucleosis			Appendicitis			Back injury		
Rheumatic fever			Hay fever			Frequent vomiting			Broken bones		
Heart trouble			Chicken pox			Gall bladder trouble or gallstones			Kidney infection		
Hypoglycemia			Arthritis			Jaundice or hepatitis			Bladder infection		
Shortness of breath			Concussion			Mononucleosis			Kidney stone		
Asthma			Frequent or severe headache			Sever or recurrent abdominal pain			Protein or blood in urine		
Pneumonia			Dizziness or fainting spells			Hernia			Hearing loss		
Chronic cough			Severe head injury			Easy fatigability			Sinusitis		
Tuberculosis			Pleurisy			Anemia or sickle cell anemia			Severe menstrual cramps		
Tumor or cancer (specify)			Epilepsy/Seizures			Eye trouble (besides glasses or contacts)			Tonsillitis		
Malaria			Disabling depression			Bone, joint or other deformity			Blood transfusion		
Thyroid trouble			Excessive worry or anxiety			Shoulder dislocation			Cancer		
Serious skin disease			Ulcer (duodenal or stomach)			Knee problems			Diabetes		
Alcohol/drug use			Intestinal trouble			Recurrent back pain			Anorexia/Bulimia		
Sexually transmitted disease			Pilonidal cyst			Neck injury			Allergy injection		

(Continued on reverse)

PERSONAL HEALTH HISTORY (continued)

1. Please list any drugs, medicines, birth control pills, vitamins and minerals (prescription and non-prescription) you use and how often you use them.

Name: ________________________________ Use_________________________ Dosage _______________

Name: ________________________________ Use_________________________ Dosage _______________

Name: ________________________________ Use_________________________ Dosage _______________

Name: ________________________________ Use_________________________ Dosage _______________

Name: ________________________________ Use_________________________ Dosage _______________

Name: ________________________________ Use_________________________ Dosage _______________

2. Do you have any disabilities? Yes _____ No _____ If yes, explain: ____

3. Do you have any insect bite allergies? Yes _____ No _____ If yes, explain: ____

4. Do you have any food or environmental allergies? Yes _____ No _____ If yes, please list allergy and symptom of each: ________________

____

5. Do you have any drug allergies? Yes _____ No _____ If yes, please list allergy and type of reaction: __________________________________

____

6. Have you ever had a positive TB skin test? Yes _____ No _____ If yes, explain: ____

7. Have you ever had any serious illness or injury other than those already noted? Yes____ No____ If yes, explain___________________________

____

INSURANCE

Please be sure you have your insurance card (or copy of insurance card—front and back) with you at college.

Check to see if your insurance plan requires you to notify them before you receive coverage away from home.

I hereby certify that the above information is complete to the best of my knowledge. I hereby authorize Maranatha Baptist University Health Services to inform the faculty and/or staff, and any health provider I may go to, of any health information that is deemed appropriate and necessary. I also give permission for the Maranatha Health Services to speak to my parents/guardian about my medical information.

____ ___________________________________

Signature of Student Date

____ ___________________________________

Signature of Parent/Guardian (if student is under 18) Date

ONLY FOR PARENTS OF STUDENTS UNDER 18

Authorization for Medical and Surgical Treatment

I, _____________________________________, the legal parent or guardian of ___________________________________, who is under 18 years of age, hereby authorize a representative of Maranatha Baptist University to sign consent papers for the medical treatment in the event of an emergency and to administer over the counter medication as appropriate and necessary.

____ ___________________________________

Signature of Parent/Guardian Date

If you have any questions, please contact Maranatha's Student Health Center at (920) 206-2384.

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