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 _____
4. Emergency Contact: Name _____ Relationship _____ Phone (_____)_____-_____

FAMILY HEALTH HISTORY

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

	Y	N	Relationship
Stroke/High Blood Pressure			
Cancer (type)			
Heart attack before age 55			

	Y	N	Relationship
Cholesterol/Blood fat disorder			
Diabetes			
Blood or clotting disorder			

	Y	N	Relationship
Alcohol/drug problems			
Psychiatric illness			
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
ADD/ADHD		
Alcohol/drug use		
Allergy Injection		
Anemia or sickle cell anemia		
Anorexia/Bulimia		
Appendicitis		
Arthritis		
Asthma		
Back Injury		
Bladder infection		
Blood Transfusion		
Bone, joint or other deformity		
Broken bones		
Cancer		
Chicken pox		

	Y	N
Chronic Cough		
Concussion		
Diabetes		
Disabling depression		
Dizziness or fainting spells		
Easy fatigability		
Epilepsy/Seizures		
Excessive worry or anxiety		
Eye trouble (besides glasses or contacts)		
Frequent or severe headache		
Frequent vomiting		
Gall bladder trouble or gallstones		
Hay fever		
Heart Trouble		
Hearing loss		

	Y	N
Hernia		
High Blood Pressure		
Hypoglycemia		
Intestinal trouble		
Jaundice or hepatitis		
Kidney infection		
Kidney stone		
Knee problems		
Malaria		
Mononucleosis		
Neck injury		
Pilonidal cyst		
Pleurisy		
Pneumonia		
Protein or blood in urine		

	Y	N
Recurrent back pain		
Rheumatic fever		
Serious Skin Disease		
Severe head injury		
Severe menstrual cramps		
Severe or recurrent abdominal pain		
Sexually Transmitted Disease		
Shortness of breath		
Shoulder dislocation		
Sinusitis		
Thyroid Trouble		
Tonsillitis		
Tuberculosis		
Tumor (specify)		
Ulcer (duodenal or stomach)		

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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