# Lincoln College Health History Form

300 Keokuk Street, Lincoln, IL 62656 Phone: (217) 732-3155 Fax: (217) 735-5214

**||||||| THIS IS NOT A PHYSICAL FORM |||||||**

## Section A

| Name–Last | First | Middle | Maiden | ID Number | |
|---|---|---|---|---|---|
| Date of Birth (MM/DD/YY) Age | Marital Status ☐S ☐M ☐D ☐W | | Citizenship (specify) ☐U.S. ☐Other | Gender ☐ M ☐ F | Date Entering LC (MM/YY) |
| Home Address | | | | Cell Phone ( ) | |
| City/State/Zip | | | | Home Phone ( ) | |

### PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Name_______________________________ Relationship_______________________

Address_______________________________ City/State/Zip _______________________

Phone (Home) _______________________________ (Work) _______________________

Cell Phone _______________________________ Pager_______________________

## Section B

| Drug/Medication Allergies: (write NONE if none) | Other Allergies: (write NONE if none) | Routine Medications Taken: (write NONE if none) |
|---|---|---|
| | | |

**Have you had any of the following? Check those that apply.**

| | | | | |
|---|---|---|---|---|
| Asthma | | Hepatitis A, B, or C | | Visual Problem (other than glasses) |
| Bleeding/Blood Disorder | | High Blood Pressure | | Alcohol Use: #times per week: __________ amount per session: __________ |
| Cancer/Tumor/Cyst | | High Cholesterol | | |
| Chicken Pox | | Kidney/Urinary Tract Problem | | |
| Counseling/Mental Health Treatment | | Malaria | | Recreational Drug Use |
| Depression | | Recent Weight Change | | Tobacco Use |
| Diabetes | | Recurrent Ear Infections | | Exercise: #times per week |
| Digestive Tract Problems | | Recurrent Headaches | | Operations/Dates |
| Eating Disorder | | Rheumatic Fever | | |
| Gynecology Problems) | | Scarlet Fever | | |
| Hay Fever | | Seizure Disorder | | Chronic Health Problems: |
| Head Injury with Unconsciousness | | Sexually Transmitted Disease | | |
| Hearing Loss | | Spinal Cord Disruption | | |
| Heart Problem/Murmur | | Thyroid Problem | | Alternative Medicine Practices: |
| Other concerns/Issues | | Tuberculosis | | |

## Section C

### Student Verification and Authorization

I certify that the above information is complete and correct to the best of my knowledge. I authorize Lincoln College Health Service to give me reasonable and proper medical care by today's standards.

Signature of Student _______________________________ Date__________

Address_______________________________ Phone_______________________