OBERLIN

Medical History/ Physical Exam

Required of all students

Please print or type.

Questions?
440-775-8180 or
student.health@oberlin.edu
(e-mail preferred)

Return to:
Oberlin College
Student Health Services
247 W. Lorain St., Suite A
Oberlin, OH 44074

Or fax to: 440-775-6404

DEADLINE: July 1, 2009

The information you provide on this form is strictly for the use of Student Health Services and the Sports Medicine Department and will not be released to anyone without your knowledge and consent. **All students must complete this form and have it signed in two places by a medical provider (M.D., D.O., N.P., or P.A.).** Enrollment will be delayed until all required sections of this form are completed.

Name: Date of Birth:

Last First Middle Month/Date/Year

Gender Race Religion Marital Status Citizenship Country of Birth

Social Security Number (if available):

Home telephone:

(Country/Area Code) Number

Home Address:

Number and Street

City State Zip Country

Parent or Legal Guardian:

Name

Address and telephone, if different from above

Who should we contact in case of emergency, if different from above?

Name Telephone

Oberlin E-mail Address:

Medical History

Allergies

Type *(food, medication, other)* Reaction

1.
2.
3.

(Please complete reverse side.)

Medical History/Physical Exam *(page 2 of 3)*

Name: ____________________

Current Medications

Name of medication — Dosage — Reason for medication

1. ____________________
2. ____________________
3. ____________________
4. ____________________

Please send a 90-day supply of any on-going medications your son or daughter will require, or make arrangements for necessary refills.

Hospitalization and or Surgery

Date — Description

____

____

Medical Illnesses or Problems

Illness or problem — Explanation

- ☐ Heart disease *(hypertension, etc.)* ____________________
- ☐ Endocrine problem *(thyroid, diabetes, etc.)* ____________________
- ☐ Epilepsy *(seizure disorder)* ____________________
- ☐ Pulmonary problem *(bronchitis, asthma, pneumonia, etc.)* ____________________
- ☐ Other ____________________

Family History

Relative — Age — State of health — If deceased, cause of death

Father ____________________

Mother ____________________

Siblings ____________________

Has any blood relative (maternal or paternal grandparents, parents, siblings) had any of the following?

Relationship — Explanation (e.g., heart attack)

Diabetes ☐ Yes ☐ No ____________________

Heart trouble ☐ Yes ☐ No ____________________

Breast cancer ☐ Yes ☐ No ____________________

Cancer ☐ Yes ☐ No ____________________

Seizure disorder ☐ Yes ☐ No ____________________

Substance abuse ☐ Yes ☐ No ____________________

Other ☐ Yes ☐ No ____________________

Social Habits

Do you smoke? ☐ Yes ☐ No — If yes, how much per day? For how many years? ____________________

Do you use alcohol? ☐ Yes ☐ No — If yes, how much per week? ____________________

Are you on a diet? ☐ Yes ☐ No — If yes, what type? ____________________

Mental Health Care (Psychiatric or Psychological)

- ☐ Eating disorder *(anorexia, bulimia)* ____________________
- ☐ Depression/Anxiety ____________________
- ☐ Alcohol/Drug treatment: Dates of treatment ____________________
- ☐ Outpatient care: Diagnosis, Dates of treatment, Medications ____________________
- ☐ Inpatient care: Diagnosis, Dates of treatment, Medications ____________________

Other Medical Information

Please note any other pertinent information (e.g., use of eyeglasses, contact lenses, dentures, etc.) that you feel would be essential to Student Health Services to ensure that you receive complete medical care while at Oberlin.

____

____

I hereby state that to the best of my knowledge, my answers to the above questions are correct.

____

Student's Signature — Medical Provider's Signature — Date

Medical History/Physical Exam *(page 3 of 3)*

Note: All items must be completed within six months prior to enrollment at Oberlin.

Patient's Name: Date of Birth:

Last First Middle Month/Date/Year

Height Weight BP

Laboratory Finding: These tests are required and must be completed within six months prior to enrollment at Oberlin.

Date ________ Vision* ________ Color Vision ________

Hct. or Hgb.* ________ Without glasses: Right 20/ ________ Left: 20/ ________

Urine*: Glucose ________ Protein ________ With glasses: Right 20/ ________ Left: 20/ ________

Hearing*: Right ________ Left ________

*may be done by your medical office

Check the proper column for each item. Enter "N.E." if not evaluated.	Normal	Abnormal	Note: Give details of each abnormality. Enter corresponding number before each comment.
1. Head, neck, face, and scalp			
2. Nose and sinuses			
3. Mouth, teeth, gingiva, and throat			
4. Ears - general (canals, drums, etc.)			
5. Eyes - general (lids, pupils, motions, etc.)			
6. Lungs, chest, and breasts			
7. Heart			
8. Vascular system (include varicosites)			
9. Abdomen and viscera (include hernia)			
10. Ano-rectal and pilondal			
11. Endocrine system			
12. Genito-urinary system			
13. Upper extremities			
14. Lower extremities			
15. Spine, other musculoskeletal			
16. Skin and lymphatic (include acne)			
17. Neurological system			
18. If female, give menstrual history; specify medication.			

Is student cleared for full participation in **all** intercollegiate varsity/club sports? ☐ Yes ☐ No

If no:

Is student cleared for participation in **non-contact** intercollegiate varsity/club sports? ☐ Yes ☐ No

Any history of emotional illness or eating disorders? ☐ Yes ☐ No

Present ☐ Yes ☐ No

Past ☐ Yes ☐ No

Any special instructions for Student Health Services while the student is in school? ☐ Yes ☐ No

If yes, provide details on reverse or on separate sheet.

Medical Provider Signature Date

Please print or stamp.

Name

Address

Telephone