Medical History/ Physical Exam

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

RETURN WITH A COPY OF YOUR CURRENT HEALTH INSURANCE CARD TO:

Oberlin College
Student Health Services
140 West College Street
Oberlin, OH 44074
OR fax to: 440-775-6404 OR e-mail:
student.health@oberlin.edu
OR upload to Student Medical Portal

▸ REQUIRED OF ALL STUDENTS

Deadline: June 15

Every Oberlin College Student is welcome to utilize the services at Student Health. Filling out this form completely and accurately assists us in providing the best care possible for you as an individual. 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 FOUR places by a medical provider (M.D., D.O., N.P., or P.A.). The medical provider completing this form cannot be a family member.
Enrollment will be delayed and you will be unable to utilize Student Health until all required sections of this form are completed.

Legal Name: _____ | Date of Birth: _____
Last First Middle Month/Date/Year

Chosen name: _____ | Pronouns: _____

Gender Identity (please specify) _____ | Sex assigned at birth: _____

Race: _____ | Religion: _____ | Marital Status: _____

Citizenship: _____ | Country of Birth: _____

Student Cell Phone: _____ | Home Telephone: _____
(Country/Area Code) Number

Oberlin E-mail Address: _____

Home Address: _____
Number & Street

_____
City State Zip Country

Parent or Legal Guardian Name: _____

_____
Address and telephone, if different from above

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

Name: _____ Telephone _____

MEDICAL HISTORY

Allergies Type: *(food, medication, other)* Reaction:

1. _____
2. _____
3. _____

Medical History *(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 ongoing medications that you will require, or make arrangements for necessary refills.

Hospitalization and/or Surgery

Date Description

_____

_____

Medical Illnesses or Problems

Yes No 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?

Yes No Relationship: Explanation e.g. heart attack:

☐ ☐ Diabetes_____
☐ ☐ Heart trouble_____
☐ ☐ Hypertension _____
☐ ☐ Cancer _____
☐ ☐ Seizure disorder _____
☐ ☐ Substance abuse _____
☐ ☐ Other_____

Social Habits

☐ ☐ Do you smoke? If yes, how much per day? For how many years? _____
☐ ☐ Do you use alcohol? If yes, how much per week? _____
☐ ☐ Do you require a special diet? If yes, what type? _____

Mental Health Care (Psychiatric or Psychological)

☐ ☐ Eating disorder _____
☐ ☐ Depression/Anxiety _____
☐ ☐ Alcohol/Drug treatment: Dates of treatment _____
☐ ☐ Outpatient care: Diagnosis, Dates of treatment, Medications_____
☐ ☐ Inpatient care: Diagnosis, Dates of treatment, Medications _____
☐ ☐ ADHD: **For medication refills at Oberlin College, must have documentation with psychological report and initial evaluation by Oberlin College Counseling Center.** (http://new.oberlin.edu/office/counseling center/)_____

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 Date Medical Provider's Signature Date

Physical Exam *(page 3 of 3)*

Name: | Date of Birth:

Last First Middle Month/Date/Year

Height: | Weight: | BP: | Pulse:

Date of Exam:_____ *All items on this page must be completed by your medical provider within 12 months prior to enrollment at Oberlin.*

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 varicosities)			
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.			
19. Vision			
20. Hearing			

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 below or stamp at right:

Name: _____

Address: _____

Telephone: _____