

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
247 W. Lorain Street, Suite A
Oberlin, OH 44074
OR fax: 440-775-6404
OR e-mail: student.health@oberlin.edu
(e-mail preferred)

▶ 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 three 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:
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease (<i>hypertension, etc.</i>)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine problem (<i>thyroid, diabetes, etc.</i>)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy (<i>seizure disorder</i>)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary problem (<i>bronchitis, asthma, pneumonia, etc.</i>)	_____
<input type="checkbox"/>	<input type="checkbox"/>	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:
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder	_____
<input type="checkbox"/>	<input type="checkbox"/>	Substance abuse	_____
<input type="checkbox"/>	<input type="checkbox"/>	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: _____