

Student Health Questionnaire

Return to: Student Programs & Services, 300 E. College Ave., Eureka, IL 61530-1500 1-309-467-6420

Information on this form may be shared with appropriate college and state health personnel for health and educational purposes.

Name: _____ Birthdate: ___/___/___ Sex: Male Female
 Last First Middle
 Social Security Number: _____

In case of emergency, contact: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: (H) _____ (O) _____

To be Completed by the Student

Are you Participating in Intercollegiate Athletics? What Sport(s)?

Allergies? (Please List) _____

Check any of the following medical conditions which you have had or are currently experiencing:

- | | | |
|---|---|---|
| <input type="checkbox"/> Chicken Pox (If so, what year?_____) | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes/Low Blood Sugar | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Anemia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Hernia |

Have you ever been treated by a physician (including osteopath, chiropractor, psychiatrist, ect.) during the last five years?

Yes No

If so, what was the treatment and result? _____

Have you been diagnosed with a learning disability? Yes No

Yes No Have you ever or do you now have:

- Dizzy or fainting spells
- Heat exhaustion, prostration, or stroke
- Chronic or persistant cough
- Shortness of breath after mild exertion
- Chest pain after exertion
- Frequent leg cramps
- Broken bone
- Head injury which required X-rays
- Back injury or recurrent low back
- Are you now under the care of a physician

Have you ever had:

- Any injury of: Shoulder Wrist Hip
 Knee Ankle

Yes No Do You:

- Wear contact lens during participation in sports
- Wear a dental appliance
- Wear a corrective brace or support
- Take medication daily for any chronic disease
- Have any other medical problems not mentioned above, If so please explain: _____

Have you ever:

- Had surgery or been advised to have surgery
- Explain: _____
- Bled excessively after injury or tooth extraction
- Allergic to any medications
- Has any physician ever advised you not to participate in sports
- Been knocked unconscious

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

SIGNATURE OF STUDENT _____ **DATE** _____