

Student Health Questionnaire

Return to: Student Programs and Services, 300 E. College Ave., Eureka, IL 61530-1500

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

In case of emergency, contact: _____ Relationship: _____

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

Telephone: (H) _____ (Cell) _____

To be Completed by the Student

If you are 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"/> 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"/> 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"/> 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:

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Dizzy or fainting spells |
| <input type="checkbox"/> | <input type="checkbox"/> | Heat exhaustion, prostration, or stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic or persistent cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath after mild exertion |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain after exertion |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent leg cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | Broken bone |
| <input type="checkbox"/> | <input type="checkbox"/> | Head injury which required X-rays |
| <input type="checkbox"/> | <input type="checkbox"/> | Back injury or recurrent low back |
| <input type="checkbox"/> | <input type="checkbox"/> | Currently under a physician's care? |

Yes No Do You:

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Wear contact lens while participating in sports |
| <input type="checkbox"/> | <input type="checkbox"/> | Wear a dental appliance |
| <input type="checkbox"/> | <input type="checkbox"/> | Wear a corrective brace or support |
| <input type="checkbox"/> | <input type="checkbox"/> | Take medication daily for any chronic disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Any other medical problems not mentioned above? If so please explain: _____ |

Have you ever:

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Had surgery or been advised to have surgery? Explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Bled excessively after injury/tooth extraction? |
| <input type="checkbox"/> | <input type="checkbox"/> | Been allergic to any medications? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has any physician ever advised you not to participate in sports? |
| <input type="checkbox"/> | <input type="checkbox"/> | Been knocked unconscious? |

Have you ever had any injury of:

- | | | | | | | |
|--------------------------|--------------------------|----------|--------------------------|-------|--------------------------|-----|
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder | <input type="checkbox"/> | Wrist | <input type="checkbox"/> | Hip |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee | <input type="checkbox"/> | Ankle | | |

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

SIGNATURE OF STUDENT _____ DATE _____