

**ARIZONA WESTERN COLLEGE -- HEALTH SERVICES / WELLNESS OFFICE
PATIENT HISTORY + CONSENT FORM**

NAME _____ **DATE OF BIRTH** _____
PLEASE PRINT: Last Name First Name Middle Name (month – day – year)

CELL PHONE / BEEPER#: _____ Residence Hall--Name w/ Room Number: _____

EMAIL: _____

IN CASE OF EMERGENCY NOTIFY: _____ PHONE: _____

LIST ALL ALLERGIES: _____

LIST ALL MEDICATIONS: _____

LIST ANY SPECIAL NEEDS / IMPAIRMENTS THAT YOU HAVE, BOTH PHYSICAL AND MENTAL: _____

CHECK OFF (✓) ALL MEDICAL CONDITIONS FOUND IN YOUR FAMILY AND PERSONAL MEDICAL HISTORIES:
 (“Family” refers to your parents and sibling)

	<i>SELF</i>	<i>FAMILY</i>		<i>SELF</i>	<i>FAMILY</i>		<i>SELF</i>	<i>FAMILY</i>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Joint Disease Injury	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety / Depression	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Eyes, Ears, Nose Prob.	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Problems	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	Skin Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Sleeplessness	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Do You Smoke	<input type="checkbox"/>	<input type="checkbox"/>
Crippling Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Do You Drink Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal/Stomach	<input type="checkbox"/>	<input type="checkbox"/>	OTHER:	<input type="checkbox"/>	<input type="checkbox"/>

Give details / dates about your health conditions checked above: _____

I drink caffeinated beverages (energy / coffee / cola / tea) # _____ per day.

In a typical week, do you drink alcohol on 3 or more occasions? Yes No

For women: During the past two weeks have you had 4 or more drinks containing alcohol in a row, on at least one occasion? Yes No

For men: During the past two weeks have you had 5 or more drinks containing alcohol in a row, on at least one occasion? Yes No

Have you smoked at least one cigarette in the past 30 days? Yes No

If yes, are you interested in quitting? Yes No

Over the past 2 weeks, have you felt down, depressed, hopeless, or stressed? Yes No

Over the past 2 weeks, have you felt little interest or pleasure in doing things? Yes No

I am bothered by excessive thirst and urination? Yes No

How many times per week do you exercise for 20 minutes or more? _____.

Do you ever experience chest discomfort or pain? Yes No If yes, when? _____

On average, I sleep _____ hours/day.

I authorize the nursing personnel of Arizona Western College Health Services to administer vaccines and to administer treatment in case of an illness or injury, for myself, or for my son/daughter if he/she is less than 18 years old. I understand that a medical Doctor is NOT available in this office. If I or my son/daughter is referred to a medical physician or provider, I understand and agree that I am responsible for paying ALL costs at the off-campus clinic or medical provider’s office. Furthermore, I authorize AWC Health Services to release immunization records to other educational institutions.

Signature of Student / Employee Date

Signature of Parent / Guardian for child under 18 Date