WESTMONT

955 La Paz Road, Santa Barbara CA 93108
805 565-6164 • health@westmont.edu

This form is required of all students.
The information is confidential and strictly for the use of the Health Center. It will not be released without your permission.

Health History and Summary of Problems

Last name | First Name | Middle Name

Birthday | Sex | Age | Social Security No. | Attended Westmont before? | What year?

Home Address | City | State | Zip Code | Phone

Father/Guardian's Name | Occupation | Work Phone | Home Phone

Mother/Guardian's Name | Occupation | Work Phone | Home Phone

In Emergency, notify | Relationship | Phone

Family Physician | Phone

Health Insurance Co. | Covered to what age? | HMO? | Policy No. for insured | Group # for insured

Ins. Phone No. (for authorizing treatment) HMO only. | Are medications covered? | Co-pay for meds.

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STUDENT HEALTH STAFF WILL COMPLETE THE THREE SECTIONS BELOW. PLEASE DO NOT WRITE IN THIS SPACE.

Continuing Problems

Date of Onset	Problem	Date Resolved	Date of Onset	Problem	Date Resolved
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Current Medications

1.	3.
2.	4.

Temporary Problems

Date	Diagnosis and Procedure	Date	Diagnosis and Procedure

Have you ever had:	No	Yes		No	Yes		No	Yes		No	Yes
ADD/ADHD			Counseling			Intestinal disorder			Tumor/Cancer		
Alcoholism/Drug			Cystic Fibrosis			Joint problems			Urine sugar/albumin		
Allergies			Depression			Kidney disorder			Other, please specify		
Anemia			Depression medication			Migraines/headaches					
Anorexia			Diabetes			Multiple Sclerosis					
Anxiety			Epilepsy/Seizures			Pneumonia					
Arthritis			Head injury			STD					
Asthma			Hearing loss			Sleep disorder/Insomnia					
Back problems			Heart condition			Thyroid disorder					
Bulimia			High blood pressure			Tuberculosis					

Menstrual History for Women

Age at onset:

Are you regular?

Flow lasts how many days?

Menstrual pain?

PLEASE EXPLAIN ANY YES ANSWERS:

Hospitalizations:

Date Reasons Date Reasons

List medications taken regularly:

List allergies to medications, foods, etc.:

If you have a medical condition, e.g. asthma, diabetes, seizures, etc., please notify your resident director when you arrive on campus.

If you are under care for a chronic condition or serious illness and wish the Health Center to provide continuing care, please provide a clinical report/instructions from your physician and arrange a meeting with Dr. Hernandez as soon as possible.

If you have a disability that impacts your academic performance and would like assistance, please contact Disability Services at 805-565-6159.

Immediate Family Medical History

	Age	Occupation	Age at Death	Cause of Death		No	Yes		No	Yes
Father					Alcoholism			Heart disease		
Mother					Arthritis			High blood pressure		
Brothers					Asthma			Kidney disease		
					Cancer (type?)			Mental illness		
					Depression			Migraine headache		
Sisters					Diabetes			Stroke		
					Epilepsy			Tuberculosis		
					Glaucoma					
Paternal G.pa										
Paternal G.ma										
Maternal G.pa										
Maternal G.ma										

Comments:

Student's signature