BERRY COLLEGE
A foundation for life

HEALTH AND WELLNESS CENTER
P.O. Box 67
Mount Berry, GA 30149
Phone: (706) 236-2267
Fax: (706) 368-6956

General Health History

The following information is deemed confidential and will be used only by the staff of the Health Center. It will only be employed to insure proper medical care and will not be released without the written consent of the student.

Personal Information

Name: _____
Last *First* *Middle*

Permanent Home Address: _____

_____ Phone: (_____) _____- _____

_____

Date of Birth: ____/____/_____ Sex: M / F Height: _____ Weight: _____
MM / DD / YYYY

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____

Phone Number: (_____) _____-_____ Alternate Phone Number: (_____) _____-_____

Family Medical History

Please indicate any items that apply to your parents, siblings, grandparents, or children.

Disease	Family Member	Disease	Family Member
High Blood Pressure		*Diabetes*	
Bleeding tendency		*Suicide*	
Anemia		*Cancer*	
Stroke		*Heart Disease*	
Mental Illness		*Tuberculosis*	
Alcoholism		*Other:* _____	

Please complete personal medical history on reverse!

Name: _____ Date of Birth: _____

Personal Health History

(Continued from reverse)

Hospitalizations/Surgeries

Please list date and reason for any hospitalizations or surgeries

Date	***Reason***	***Comments***

Personal History

Please indicate the presence or absence of a personal history of all of the following. If you answer yes to any of these items, please indicate the approximate year in which they occurred.

Disease	History	Year	Disease	History	Year	Disease	History	Year
Anemia	Y / N		Tuberculosis	Y / N		Sexually transmitted disease	Y / N	
Bleeding tendency	Y / N		Bronchitis	Y / N		Pelvic inflammatory disease	Y / N	
Phlebitis/Blood clots	Y / N		Pneumonia	Y / N		Prostate infection	Y / N	
High blood pressure	Y / N		Emphysema	Y / N		Epididymitis	Y / N	
Hepatitis	Y / N		Alcoholism	Y / N		Bladder infection	Y / N	
Thyroid problems	Y / N		Depression	Y / N		Kidney infection	Y / N	
Hypoglycemia	Y / N		Mental Illness	Y / N		Yeast infection	Y / N	
Diabetes	Y / N		Epilepsy/Seizures	Y / N		Colitis	Y / N	
Chicken pox/shingles	Y / N		Neurological Disorders	Y / N		Fibrocystic Disease	Y / N	
Strep throat	Y / N		Vision Problems	Y / N		Ulcers/stomach problems	Y / N	
Mononucleosis	Y / N		Eating Disorder	Y / N		Back problems	Y / N	
Sinus problems	Y / N		Concussion/head injury	Y / N		Orthopedic injuries	Y / N	
Allergies/hay fever	Y / N		Headaches/migraines	Y / N		Rheumatic fever	Y / N	
Asthma	Y / N		Hearing problems	Y / N		Other: _____	Y / N	

Known food and/or drug allergies (*if none known, please note this*): _____

Have you ever filed a claim for worker's compensation? If so, what was the reason?: _____
_____

I attest that the information I have given is accurate and complete to the best of my knowledge, and I understand that the Health Center will not release this information to any third party without my written consent.

Student Signature: _____ ***Date***: _____

Or signature of legal guardian if student is under the age of 18