Health & History Form

Personal and Health History

(Medical and personal information is confidential. This information will be used in accordance with Grand Canyon University Notice of Privacy Practices)

Last Name _____ First Name _____ Middle _____

DOB ____ / ____ / ____ S.S. # _____ Student ID # _____

Mailing Address _____

School Mail Box # _____ School Phone # or ext. _____

Cell/Home Phone # _____

Emergency Contact

Name _____ Relationship _____

Home Phone # _____ Business Phone # _____

Immunizations

Two MMR (Measles, Mumps and Rubella), a titer or born prior to January 1, 1957 is required to attend Grand Canyon University (see student handbook for details). You will not be permitted to register without proof of immunizations on file. (Please attach a COPY of proof of immunizations – NOT THE ORIGINAL.)

Medical and Financial Consent

I hereby consent to the performance of medical or minor surgical treatment and the prescribing of necessary or requested medication by the Grand Canyon Health & Wellness Center health care staff while attending or working at Grand Canyon University. In addition, I am financially responsible for any charges that may incur as a result of care obtained, which is not covered by my health insurance.

Parent/Guardian (for students under 18)

Signature _____ Date _____

Student Signature _____ Date _____

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Health History

Are you allergic to any substance including medications? ☐ Yes ☐ No

If yes, please list the substance and your reaction to it: _____

I am currently taking the following medications (please list dosages): _____ _____

_____ _____

_____ _____

I am under treatment and seeing a provider for: _____

I am receiving or need counseling for: _____

I have the following disability: _____

Indicate if you have or have had the following:

☐ Asthma ☐ Heart Disease ☐ Kidney Disease ☐ Convulsions ☐ Hepatitis ☐ Lung Disease ☐ Diabetes ☐ High Blood Pressure

☐ Muscle/Joint Disorder ☐ Eating Disorder ☐ Immune Disorder ☐ Thyroid Disease ☐ Alcohol or Drug Abuse ☐ Mental Illness

☐ Migraines/Headaches

Indicate the last time you had (years):

Flu vaccine _____ Hepatitis vaccine _____ TB skin test _____ Eye exam _____ Cholesterol screening _____ Dental exam _____

Indicate if you have used the following by Yes or No:

Cigarettes ☐ Yes ☐ No If yes, packs per day ___ # of years ___

Alcohol ☐ Yes ☐ No If yes, # of drinks per week ___ # of years ___

Caffeinated drinks ☐ Yes ☐ No If yes, # of drinks per week ___

For Women Only:

Date of last menstrual period _____ Pain _____ Regular Cycle _____

Last well woman exam _____ (normal/abnormal) Mammogram _____

Do you perform monthly breast exams? _____

For Men Only:

Do you perform monthly testicular exams? _____