CORNERSTONE UNIVERSITY HEALTH SERVICES

HEALTH HISTORY

All new students are required to complete and return this form.
It may be submitted online, by mail, or by fax. See contact information at page bottom.

GENERAL INFORMATION:

Last Name (Print), First, Middle	Date of Birth	Cornerstone ID #
Home Street Address	Student Status: F S J S Grad.	Year Entering Cornerstone
Home City, State, Country, Zip/Postal Code	Sex: M F	Marital Status: S M D W
E-mail Address and Cell Phone	Height	Weight

PARENT or GUARDIAN CONTACT INFORMATION:

Last Name (Print), First, Middle	Relationship	Home Phone
Home Street Address, City, State, Country, Zip/Postal Code		Work Phone
Alternate Address	E-mail Address	Cell Phone

ALTERNATIVE EMERGENCY CONTACT INFORMATION (local or nearest Cornerstone, if you have one):

Last Name (Print), First, Middle	Relationship	Home Phone
Home Street Address, City, State, Country, Zip/Postal Code		Work Phone
Alternate Address	E-mail Address	Cell Phone

PERSONAL HEALTH HISTORY: Please answer the following and provide pertinent information:

- ☐ I have been treated by a health care provider or therapist for a health concern. Please list:
- ☐ I am taking prescription medications regularly. Please list:
- ☐ Hospitalizations/Surgeries: Please list, with dates:
- ☐ Food or drug allergies: Please list:
- ☐ I have received services for a disability. Please list:

Select any of the physical or mental problems you currently have or have ever had. Please enter the dates you had them.

	ADHD		Heart Problems
	Allergy injections		Hepatitis/ Liver Disease
	Anxiety and/or depression		High Blood Pressure
	Asthma		Kidney/Urinary Problems
	Bipolar Disorder		Neurological Problem or Seizures
	Bone/Joint Problems		Skin Problem
	Cancer		Sleep Disorder
	Diabetes		Thyroid Disorder
	Eating Disorder/Low Weight		Vision(other than corrective lenses)/Hearing
	Headaches		Other/Not Listed