Mount Saint Mary's University
LOS ANGELES

Health History Form

To be completed by student. All information is confidential.

Last Name:	First Name:	Student ID:
Gender:	Date of Birth:	Cell phone:
Address:		
Email:	Campus: Chalon Doheny	Commuter Resident
First Year Sophomore Junior Senior A.D.N ABSN DPT RN to BSN		Major:
Is this your first semester as a Transfer Student to MSMU: yes no		

In Case of Emergency notify:

Emergency Contact Name:	Relationship:
Phone:	Address:

Family Background: Has anyone in your immediate family or blood relatives had any of the following?

	Yes	No	If yes, please specify:
High blood pressure			
Diabetes			
High Cholesterol			
Stroke or heart attack before age 50			
Cancer			
Psychiatric illness			

How do you rate your health? (please check) ☐ **Above Average** ☐ **Average** ☐ **Below Average**

Personal History

	Yes	No	If yes, please specify:
Are you currently under the care of a Physician?			Reason:
Do you take any medications? List all prescription or over-the-counters			
Do you have any allergies? List all environmental, food, medications, etc.			
Do you smoke?			How many per day?
Do you drink alcohol?			How much per week?
Do you use Recreational drugs?			How much per week?
Do you have or ever had Anorexia or Bulimia?			
Do you exercise regularly?			What type and how often?

Please continue to back side. Signature(s) required at the end of the questionnaire.

Have you ever had or do you have any of the following?

	Yes	No	If yes, please specify:
Anemia			
Anxiety / Depression / other Emotional illness			
Asthma or Hay fever			
Blood clot or Vein problem			
Bone, Joint or Muscle problem			
Cancer			Type:
Diabetes			Since: On insulin? yes no
Digestive / Abdominal problem / Ulcer			
Fainting / Dizzy spells			
Genital / Urinary problem			
Headaches			
Headaches, Migraine (diagnosed)			
Hearing Loss			
Heart murmur / other Heart problem			
Hepatitis / Jaundice / Liver problem			
High blood pressure			
High cholesterol (diagnosed)			When diagnosed?
Kidney disease			
Seizures or Epilepsy			Type:
Surgery			
Thyroid problem			
Tuberculosis			

For Women

	Yes	No	If yes, please specify:
Have you had a Pap smear?			Date: Were the results normal? yes no
Are you pregnant or breastfeeding?			
Do you have any GYN problems / disorders?			

Authority and consent is given to Mount Saint Mary's University to cause the examination and treatment at Student Health Services by a member of the Mount Saint Mary's University professional nursing staff, an outside physician or nurse practitioner and medical facilities as are available in cases of illness and/or injury as well as University health requirements. Consent is further given for necessary admission for medical or surgical treatment in a hospital. It is agreed that all medical and/or hospital expenses incurred beyond those covered by any applicable health insurance will be the direct responsibility of the undersigned student and/or parent or guardian and the University will not be responsible thereon.

I agree to pay the total fees for services received at Mount Saint Mary's Student Health Services at the time of my visit.

Student Signature:	**Date:**
If under 18, Parent/Legal Guardian Signature:	Date:

PLEASE MAKE A PERSONAL COPY OF ALL RECORDS BEFORE SENDING.

Chalon Student Health Services 12001 Chalon Road, Los Angeles, CA 90049-1526 or fax 310.954.4119

Doheny Student Health Services 10 Chester Place, Los Angeles, CA 90007-2598 or fax 213.477.2683

All forms can be downloaded from www.msmu.edu/healthforms

Rev 07/2017