PennWest UNIVERSITY

Health Services Confidential Health Record

Information provided will not be used to influence your situation at the University. This information is strictly for the use of Health Services and will not be released to anyone without your knowledge and consent except in the event of an emergency medical situation.

PennWest students are responsible for communicating their health information to the appropriate departments.

Name:_____ Date of Birth:_____ Gender:_____ Cell Phone #:_____

Permanent Home Address:_____

Street City State Zip

In Case of Emergency Notify: Name:_____ Relationship:_____ Phone #:_____

Address: _____

Street City State Zip

Allergies (Medication/Food/Environmental/Other):_____

List any **medications** you are currently taking on a regular basis: _____

Family Medical History (Check all that apply):

Asthma		Cancer		Epilepsy		Kidney Disease	
Alcohol/Drug Use		Diabetes		Heart Disease		Tuberculosis	
Other/Specifications:							

Do you or have you ever had any of the following? (Check all that apply):

ADD/ADHD		Concussion(s)		Hepatitis Type:		Prostatitis	
Alcohol/Drug Problem		Depression		High Blood Pressure		Recurrent Ear Infections	
Anxiety		Diabetes Type		HIV/AIDS		Recurrent Sinusitis	
Asthma		Eating Disorder Type:		Kidney Disorders Specify:		Rheumatoid Arthritis	
Bipolar Disorder		Epilepsy/Seizure Disorder		Migraines		Scoliosis	
Bleeding Disorder Specify:		Eye Disorder/Disease		Mononucleosis		Sickle Cell Anemia	
Blood Clots		Fainting		Multiple Sclerosis		Skin Condition Specify:	
Bone Disease Specify:		GI Disorders Specify:		Mumps		Spina Bifida	
Cancer/Tumor		GERD/Heartburn		Muscular Dystrophy		Suicide Attempt(s)	
Cerebral Palsy		Head Injury		Panic Attacks		Systemic Lupus Erythematous	
Chicken Pox		Heart Condition Specify:		Peptic Ulcers		Thyroid Conditions Specify:	
Chronic Tonsillitis		Heart Murmur		P.O.T.S		Tuberculosis	
Other/Specifications:							

Surgeries (Check all that apply):

Adenoidectomy		Tonsillectomy	
Appendectomy		Wisdom Teeth	
Bone/Joint Surgery		Other/Specify:	
Cholecystectomy			

Disability (Check all that apply if you have a disability that requires special consideration from the University):

Emotional		Mobility	
Hearing		Vision	
Learning:		Other/Specify:	

I authorize Health Services to release this form to myself, another health care facility, place of employment or academic department, upon my request.

_____ P _____ California / Edinboro

Student Signature Student ID# Date Campus (Circle One)

PennWest UNIVERSITY

*** THIS SIDE TO BE FILLED OUT BY MEDICAL PROVIDER ***

This report MUST be on file with the appropriate PennWest campus' Health Services below prior to the student's enrollment date. Please attach a copy of the insurance card(s), front and back, to this form, if applicable.

Return to: PennWest California Health Services
Student Health Center
250 University Avenue
California, PA 15419
Phone: 724-938-4232 Fax: 724-938-4509

PennWest Edinboro Health Services
Ghering Health & Wellness Center
300 Scotland Road
Edinboro, PA 16444
Phone: 814-732-2743 Fax: 814-732-2666

Report of Health Evaluation

To the examining provider: Please complete this side of the form. Please comment on all positive answers. **This information is strictly for the use of Health Services and will not be released without student consent except in an emergency situation.**

Name: _____ SS#: _____ Date of Birth: _____

Vaccine:	Date(s):			
DPT (initial series; 3 inj; required)				
TD Tdap-Booster (past 10 years)				
Polio (series of 3 doses)				
MMR (series of 2 doses)				
Hepatitis B (series of 3 doses)				
Hepatitis A (series of 3 doses)				
HPV Vaccine (series of 3 doses)				
Meningitis Vaccine				
COVID-19 Vaccine				
Other:				

Last Tuberculin Skin Test: Date _____ Result: _____

BP: _____/_____ Height: _____ Weight: _____ lbs. Corrected Vision: Right: 20/_____ Left: 20/____

Are there any abnormalities of the following systems? Describe fully. Use additional space if necessary.

Head, Ear, Nose, Throat:	Yes	No	Genitourinary:	Yes	No
Respiratory:	Yes	No	Musculoskeletal:	Yes	No
Cardiovascular:	Yes	No	Metabolic/Endocrine:	Yes	No
Gastrointestinal:	Yes	No	Neuropsychiatric:	Yes	No
Hernia:	Yes	No	Skin:	Yes	No
Eyes:	Yes	No	Loss/impaired function of any organ:	Yes	No
Recommendations for physical activity (Phys Ed, Intramurals, ROTC): Explain:				Yes	No
Do you have any recommendations regarding care of this student?				Yes	No
Is the student now under treatment for any medical or emotional condition?				Yes	No
General Comments:					

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Health Care Provider's Signature: _____

Print Last Name: _____ Phone #: _____

Address: _____ Date: _____