

**PLEASE INDICATE  
STUDENT STATUS**

RSMD  SOPS   
 Talbot  SOE   
 ICS  Other   
 Previous Biola Student? Y  
 N

**BIOLA UNIVERSITY  
STUDENT HEALTH CENTER**

13800 BIOLA AVENUE  
 LA MIRADA, CA 90639-0001  
 PH: 562- 903-4841 ▲ FAX: 562-906-4512

**PLEASE LIST  
DRUG/FOOD/BEE  
ALLERGIES**

**GRADUATE STUDENT HEALTH HISTORY**

Biola ID \_\_\_\_\_ M  F

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_ Home Phone # \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Birthplace \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Citizenship \_\_\_\_\_ Ethnicity (opt.) \_\_\_\_\_

Emergency contact & Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

**PERSONAL HISTORY**

History of injuries &/or operations: (Give nature & year) \_\_\_\_\_

History of previous illness: (give year &/or status)

Appendicitis \_\_\_\_\_ Epilepsy \_\_\_\_\_ Pneumonia \_\_\_\_\_

Asthma \_\_\_\_\_ Kidney Disease \_\_\_\_\_ Rheumatic Fever \_\_\_\_\_

Cardiac Condition \_\_\_\_\_ Malaria \_\_\_\_\_ Seasonal Allergies \_\_\_\_\_

Diabetes \_\_\_\_\_ Mononeucleosis \_\_\_\_\_ Tuberculosis \_\_\_\_\_

Have you had any other severe illness not mentioned above? If so, please explain. \_\_\_\_\_

Number of Pregnancies \_\_\_\_\_ Number of Live Births \_\_\_\_\_

Can you eat a normal, balanced diet? \_\_\_\_\_ If not, explain. \_\_\_\_\_

In what sports do you regularly participate? \_\_\_\_\_

Emotional problems? (be specific) \_\_\_\_\_

Have you ever used any psychoactive or addicting drugs, with or without a prescription? Please explain. \_\_\_\_\_

**GENERAL APPEARANCE**

Height \_\_\_\_\_ Weight \_\_\_\_\_

EYES: Color \_\_\_\_\_ Last eye exam \_\_\_\_\_ Vision Corrected \_\_\_\_\_ Uncorrected \_\_\_\_\_ Contacts? Y N Glasses? Y N

TEETH: Last visit to dentist \_\_\_\_\_ Need dental work? \_\_\_\_\_

**FAMILY HISTORY**

Name	Alive	Chronic Illnesses?	Deceased	Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				
Spouse				
Children				

**Have any of your family or blood relatives ever had any of the following illnesses? Please give relationship.**

Asthma	High Blood Pressure
Cancer (type)	Kidney Disease
Diabetes	Mental Disturbance
Heart Disease	Tuberculosis
Any chronic illness not mentioned	

\*\* (See other side for Immunization and Tb validation requirements)

