

CHECK ALL THAT APPLY

- Freshman
 Sophomore
 Junior
 Senior
 Previous Biola Student? Y N
 Date of last Semester _____

BIOLA UNIVERSITY

STUDENT HEALTH CENTER

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

*** All students under
 18 please have parent
 or guardian signature
 below for treatment.**

UNDERGRADUATE STUDENT HEALTH HISTORY/PHYSICAL EXAM

Date _____
 Last Name _____ First Name _____ Middle Name _____
 Address _____ Home Phone # _____
 City, State, Zip _____
 Birthplace _____ Age _____ Date of Birth _____
 Emergency contact & Relationship: _____ Phone # _____
 Citizenship _____ Ethnicity (opt.) _____

* AUTHORIZATION FOR TREATMENT

**THIS IS TO BE COMPLETED AND SIGNED BY STUDENTS THAT ARE UNDER AGE EIGHTEEN (18) AND MUST
 HAVE THE SIGNATURE OF THE STUDENT'S PARENT/GUARDIAN.**

I give my consent for my student to receive treatment for illness or injury, medication or immunization deemed advisable through the Biola University Health Service, and to make the necessary referrals to other facilities, if indicated.

Student's Signature _____ Parent/Guardian Signature _____ Date Signed _____

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 _____ Mononucleosis _____ Tuberculosis _____ Varicella(chicken pox) _____

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

Number of Pregnancies _____ Number of Live Births _____

Have you ever been diagnosed with an eating disorder? _____

How often do you exercise? Daily 30-60 mins. _____ 3x weekly 30-60 mins. _____ or other _____

Have you ever been diagnosed with psychological problems? (please explain) _____

Are you using psychoactive or addicting drugs, with or without a prescription? Please explain and state drug name. _____

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	

RETURN FORM TO :
 Biola University Health Center
 13800 Biola Avenue
 La Mirada, CA 90639-0001 or
 FAX: 562.906.4512

HEALTH RECORD AND EXAMINATION

To be completed by M.D./N.P./P.A.

*** PLEASE NOTE
 REQUIRED
 IMMUNIZATIONS.**

Name (Last, First, MI): _____

Date of examination _____ Age _____ Date of Birth _____ Sex _____

Blood pressure _____ Pulse rate _____ Height _____ Weight _____

Allergies: Drugs _____ Food _____ Bee/Other _____

Check each item N (normal) or A (abnormal)		Remarks	Remarks	
Posture			Lungs & Chest	
Joints			Breasts (females)	
Speech			Abdomen	
Skin & Lymphatic			Back & Spine	
Nose & Sinuses			Genitourinary System	
Ears			Endocrine System	
Mouth, Throat, Tonsils			Nutrition	
Teeth, Breath, Gums			Nervous System	
Eyes			Menstrual Cycle/Testes	
Heart			Emotional Problems	

***LAB: MUST BE COMPLETED**

*Urinalysis: Glucose: _____ Protein: _____ *Hematocrit or Hemoglobin: _____

Tuberculosis Test (MANTOUX only!!) Within 1 year of exam. Must be completed in the United States.

Date applied: _____ Date read: _____ Results: _____

If POSITIVE, must have chest x-ray within 2 yrs. Date of CXR: _____ Results: _____

Medications prescribed (past 2 yrs & current) _____

Operations _____

***REQUIRED IMMUNIZATIONS: PLEASE SUPPLY DATES OF IMMUNIZATIONS and PLEASE UPDATE IF NEEDED**

- *Tetanus-Diphtheria (booster within the last 10 years) _____
- *MMR(Measles, Mumps, Rubella) Dose 1 _____ Dose 2 _____ *(two dates required by Biola University)
 Measles (Rubeola): disease date _____ Mumps: disease date _____ Rubella: disease date _____
- *Varicella (chicken pox): Dose 1 _____ Dose 2 _____ disease date _____
 Gardasil (not a requirement) Dose 1 _____ Dose 2 _____ Dose 3 _____
- *Polio: Completed primary series? (4 dates) Yes _____ Date of last booster _____ If No, get completed series.
- *Hepatitis B Dose 1 _____ Dose 2 _____ Dose 3 _____ *(three dates required)
- *Hepatitis A Dose 1 _____ Dose 2 _____ (two dates required)
- *Menactra A/C/Y/W-135 (Meningococcal vaccine) _____

SIGNATURE OF M.D./N.P./P.A. _____ OFFICE STAMP _____

PRINTED NAME _____

PHONE NUMBER _____