Please upload the completed form to your Salem College Magnus Health account by August 1. For Magnus technical support questions, please contact the IT Help Desk at help@salem.edu.

HEALTH INFORMATION FORM

To be completed by the student. Please print in black ink.

LAST NAME ___________________________________FIRST _______________________________ MIDDLE ____________________________

PERMANENT ADDRESS ____

CITY ____STATE _______________ZIP CODE __________________________

PHONE NUMBER (______)________________________ DATE OF BIRTH ______/______/_________ SOC. SEC. NUMBER_______-_______-________

MARITAL STATUS _________________ GENDER____________________

CLASS YOU ARE ENTERING (CIRCLE): FY SO JR SR

SEMESTER ENTERING (CIRCLE): FALL SPRING SUMMER 1 SUMMER 2 YEAR 20______

INSURANCE INFORMATION

Due to the Affordable Care Act, everyone is expected to have health insurance. Please take the time to double check your insurance plan to make sure it will cover care in North Carolina. If it does not, you may wish to look into getting insurance through the federal insurance exchange [www.healthcare.gov].

A copy of insurance card, front and back is REQUIRED

NAME AND ADDRESS OF HEALTH INSURANCE COMPANY______________________________

____

AREA CODE/TELEPHONE NUMBER ____

NAME OF POLICY HOLDER ____

SOC. SEC. NUMBER OF POLICY HOLDER_________-____________-____________ DOB OF POLICY HOLDER ______/______/_________

EMPLOYER ____

POLICY OR CERTIFICATE NUMBER _________________________________ GROUP NUMBER __________________________________

IS THIS AN HMO/PPO.MANAGED CARE PLAN? YES NO

PERSONAL HISTORY

Do you have now or have you ever had (circle all that apply):

1. ADD OR ADHD
2. ANEMIA
3. ANOREXIA/BULIMIA
4. APPENDECTOMY
5. ARTHRITIS
6. ASTHMA
7. BLIND/VISUAL IMPAIRMENT
8. CANCER/ MALIGNANCY
9. CHICKENPOX
10. CROHN'S/IBS/COLITIS
11. CHRONIC HEALTH PROBLEMS
12. DEAF/ HEARING IMPAIRMENT
13. DEPRESSION
14. DIABETES
15. EMOTIONAL/ MENTAL ILLNESS
16. HEART DISEASE/ PROBLEM
17. HEPATITIS (TYPE_______)
18. HIGH BLOOD PRESSURE
19. HIGH CHOLESTEROL
20. HIV INFECTION/DISEASE
21. IMPAIRED MOBILITY/ PARALYSIS
22. KIDNEY DISEASE
23. LEARNING DISABILITY
24. LOSS OF PAIRED ORGAN
25. MALARIA
26. MIGRAINE/CHRONIC HEADACHE
27. MONONUCLEOSIS
28. NEUROMUSCULAR DISEASE
29. PARASITE INFECTION
30. PHLEBITIS/ DEEP VEIN
31. PNEUMOTHORAX
32. SEIZURE DISORDER
33. STD
34. SICKLE CELL DISEASE
35. THYROID DISEASE
36. POSITIVE TB TEST
37. TUBERCULOSIS DISEASE
38. ULCER/ STOMACH PROBLEMS
39. UTI/ FREQUENT
40. OTHER

Please explain all circled answers including dates:

____

____

____

Please list all hospitalizations (include all medical/psychiatric hospitalizations, dates, and diagnosis):

____

____

Do you have now or have you ever had (circle all that apply):

1. Irregular periods/no periods
2. Polycystic Ovary Syndrome
3. Genital Warts
4. Pelvic Inflammatory Disease (PID)
5. Genital Herpes
6. Breast Lumps/Fibrocystic Disease
7. Sexually Transmitted Infection
8. Use Contraception
9. Pregnancy (live births)__________
10. Use Oral Contraceptives
11. Abortion/Miscarriage #_____
12. Other______________

WELLNESS PROFILE

1. Do you smoke Cigarettes? _____Yes, _____No. Number per Day________. For how many years?_________
2. Do you drink Alcohol? ____Yes, ___No. If yes, how often? ______When you drink, how many do you usually have_________
3. Do you now or have you ever used recreational drugs ___Yes, ___No. If yes, which ones? ____________________________ How Often? ____________________
4. How often do you exercise? __Never, __Daily, __3-5 times a week, __Weekly. What type of exercise____________________
5. Do you follow a diet? __Yes, __No. If so what kind? _________________. Are you concerned about your eating habits? ___Yes, ___No.
6. Do you often have a feeling of being anxious, overwhelmed or depressed? ___Yes, ___No.
7. Have you ever received counseling for emotional problems? ___Yes, ___No.
8. Are you currently in counseling/therapy? ___Yes, ___No. Dates of treatment____

MEDICATION & ALLERGY INFORMATION

Please list all medications you are taking. Please include prescription and non-prescription medications. This includes vitamins, minerals, herbal supplements, and allergy injections.

MEDICATION	DOSE	USE	ALLERGY	YES	NO	EXPLAIN
1.			PENICILLIN			
2.			SULFONAMIDES			
3.			ASPIRIN			
4.			CODEINE			
5.			OTHER DRUGS			
6.			INSECT BITES			
7.			PEANUTS			
8.			OTHER FOODS			
9.			LATEX			
10.			OTHER			

IMPORTANT INFORMATION - PLEASE READ AND COMPLETE

STATEMENT BY STUDENT (OR PARENT/GUARDIAN, IF STUDENT UNDER AGE 18):

(A) I have personally supplied (reviewed) the personal health history information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (minor student's) medical record to a physician, hospital, or other medical professional involved in providing me (minor student) with emergency treatment and/or medical care.

(B) I hereby authorize any medical treatment for myself (minor student) that may be advised or recommended by the healthcare providers of Student Health Services.

(C) I understand that I am responsible for any charges not covered by insurance for services received by an outside provider (i.e., laboratory, pharmacy, emergency room, consulting physician).

____ ____________________

Signature of Student (Over 18 Years of Age) Date

____ ____________________

Signature of Parent/Guardian (Student Under 18 Years of Age) Date

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EMERGENCY CONTACT INFORMATION

NAME OF PERSON TO CONTACT____

RELATIONSHIP ____________________ PHONE NUMBER (______)____________________

ADDRESS________________________CITY____________STATE_______ZIP____________