



Please upload this form into your Magnus Health account. For IT assistance related to Magnus Health, email [help@salem.edu](mailto: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 \_\_\_\_/\_\_\_\_/\_\_\_\_ MARITAL STATUS \_\_\_\_\_

GENDER: \_\_\_\_\_ PRONOUN PREFERENCE: \_\_\_\_\_

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

SEMESTER ENTERING (CIRCLE): FALL SPRING STARTING ACADEMIC YEAR: \_\_\_\_\_

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

- |                                      |                                     |                                  |
|--------------------------------------|-------------------------------------|----------------------------------|
| 1. Irregular periods/no periods      | 5. Genital Herpes                   | 9. Pregnancy (live births) _____ |
| 2. Polycystic Ovary Syndrome         | 6. Breast Lumps/Fibrocystic Disease | 10. Use Oral Contraceptives      |
| 3. Genital Warts                     | 7. Sexually Transmitted Infection   | 11. Mental Health Diagnosis      |
| 4. Pelvic Inflammatory Disease (PID) | 8. Use Contraception                |                                  |

**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 \_\_\_\_\_
9. Have you ever been diagnosed with COVID? If yes, when? \_\_\_\_\_
  - a. Do you have any long term side effects from COVID? Please explain \_\_\_\_\_

**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

**EMERGENCY CONTACT INFORMATION**

NAME OF PERSON TO CONTACT \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ PHONE NUMBER(\_\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_