

MEDICAL HISTORY

GOLDEN STATE BAPTIST COLLEGE

**Mail to Admissions Office
Golden State Baptist College, 3520 De La Cruz Blvd., Santa Clara, CA 95054**

Please type or print in ink. Please fill out completely.

Name: _____
Last First Middle

Mailing Address: _____
Street City State Zip

Telephone Number: (____) _____

Marital Status: Single Married Gender: Male Female Age: _____

Birth Date: ____ / ____ / ____

Do you have medical insurance? Yes No

Policy #: _____ Identification #: _____

EMERGENCY CONTACT

Name: _____
Last First Middle

Telephone Number: (____) _____ Relation: _____

MEDICAL HISTORY

I am currently taking medication prescribed by a physician. Yes No

I have been hospitalized in the past two years. Yes No

Have you had any major injuries? Yes No *(If yes, please list them)* _____

Have you had any major surgeries? Yes No *(If yes, please list them)* _____

Have you ever lost consciousness? Yes No *(If yes, please explain and state the last time)* _____

List any medications you take regularly: _____

List all foods and medications you are allergic to: _____

Have you ever sought psychiatric counsel? Yes No *(If yes, please explain in a separate letter, include circumstances, and list any medications prescribed.)*

...continued on back

STUDENT HISTORY

(Indicate the conditions you have had with an X in the)

- | | | |
|-------------------------------------------------|----------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> AIDS or HIV positive | <input type="checkbox"/> Fainting Attacks | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Head Colds (frequent) | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches (frequent) | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anxiety/Panic Attacks | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Chest Colds (frequent) | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney or Bladder Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tonsillitis (frequent) |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Trouble With Eyes |
| <input type="checkbox"/> Drug Flashbacks | <input type="checkbox"/> Malaria | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Typhoid Fever |

FAMILY HISTORY

(Indicate if your parents, grandparents, brothers or sisters have been diagnosed)

- | | | |
|---------------------------------------|----------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Brain Tumors | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Leukemia |
| | | <input type="checkbox"/> Mental Disease |

OTHER INFORMATION

Please list all other medical and health information about which the staff of Golden State Baptist College should know.

Your signature below signifies that this information is true and complete to the best of your knowledge.

Student's signature: _____ Date: ____ / ____ / ____