Office	Use	Only
RN	MD	PPD

SANTA CLARA UNIVERSITY

COWELL STUDENT HEALTH CENTER
PERSONAL HEALTH HISTORY

A Physician's Signature is NOT REQUIRED to complete this form

Please mail this form to: Cowell Health Center, Santa Clara University, 500 El Camino Real, Santa Clara, CA 95053

The purpose of this form is to ensure that every student received optimal health care when visiting the Cowell Health Center. By having this information on file, the Cowell Health Center Team will be able to better assist the student at the time of the visit.

STUDENT STATUS: (Circle) FR SO JR SR LAW GRAD

Name: _____ Sex M_____ F_____
Last First MI
Birthdate: _____ Student ID #: _____

Address: _____ Phone ( )_____
Street City State Zip
Parent/Guardian/Significant Other_____

Address: _____ Phone ( )_____
Street City State Zip Home
Phone ( )_____
Work

Height:	Weight:	Allergies: (Medications, Materials or Other)

Please list any past or present medical conditions:

Medical Condition	Treatment	Year

List any medications you currently take: (include over the counter meds, contraceptives, herbal drugs, or supplements)

Medication Name	Dosage	Frequency	Reason

IMMUNIZATION INFORMATION – See Other Form