THE MASTER'S COLLEGE
For Christ & Scripture

Health Center
Student Health History

Name_____
Last *First* *Middle*

Home Address _____ City_____ State_____ Zip_____

_____
Student Signature *(Parent Signature if under 18)* *Date*

Medical Insurance

Note: Unless the student submits an insurance waiver online, all students are automatically enrolled in health insurance, sponsored by The Master's College and managed by Wells Fargo Insurance Services. Waivers will be approved based on the health plan. Students must submit a waiver once per academic year. The fall waiver deadline is September 12th. The spring deadline is January 30th (for students entering in the spring semester only).

Once your insurance waiver has been approved, please email or mail a copy of the front and back side of your insurance I.D. card so we can keep it in your file.

The following is solely for The Health Center's information, and does not constitute signing the waiver or enrolling with The Master's College Insurance. Please check one of the following:

☐ I will be covered by The Master's College Student Insurance.

☐ I am covered by the insurance program listed in the box.
Place an **x** on the box that corresponds with your insurance.

☐ Elect Choice (EPO)
☐ Health Maintenance Org. (HMO)
☐ Point of Service (POS)
☐ Preferred Provider Org. (PPO)
☐ Private
☐ Medi-Cal

Personal Medical History

Please check if you currently have or previously had the following:

	Yes	No		Yes	No		Yes	No
Alcoholism/Drugs	○	○	Diabetes	○	○	Mononucleosis	○	○
Allergies medicine, insects, pollen, dust	○	○	Diabetes Medication Insulin	○	○	Multiple Sclerosis	○	○
Anemia	○	○	Epilepsy/seizure	○	○	Pneumonia	○	○
Anorexia/bulimia	○	○	Eye trouble/glasses	○	○	Shortness of breath	○	○
Anxiety/panic attacks	○	○	Head injury	○	○	Sinus problems	○	○
Date of last panic attack			Hearing loss	○	○	Sleep disorder/insomnia	○	○
Arthritis	○	○	Heart palpitations	○	○	Stomach/intestinal problems	○	○
Asthma	○	○	Heart condition	○	○	STDs	○	○
Back pain	○	○	High/low blood pressure	○	○	Thyroid disorder	○	○
Cancer/tumor	○	○	Hepatitis/jaundice	○	○	Urinary tract problems	○	○
Chest pain/pressure	○	○	Joint injury	○	○	Weakness/paralysis	○	○
Chicken pox	○	○	Kidney disorder	○	○	Depression	○	○
Chronic cough	○	○	Malaria	○	○			
Cystic Fibrosis	○	○	Migraines/headaches	○	○			

Female Students:

Please check if you currently have or previously had the following:

	Yes	No		Yes	No
Bladder infections	○	○	Medication for cramps	○	○
Heavy periods/severe cramps	○	○	Pregnancy	○	○
Hormone therapy	○	○	Other	○	○

Please explain any yes answers: _____

_____

_____

Have you ever been hospitalized? ☐Yes ☐No

Are you currently taking any medications? ☐Yes ☐No

Do you have any chronic illnesses? ☐Yes ☐No

Do you have any limitations or disabilities? ☐Yes ☐No

Please explain any yes answers (including applicable dates)**:** _____

_____

_____

Family History

Please check if a blood relative currently has or previously had the following:

	Yes	No	Relation		Yes	No	Relation
Allergies	○	○		Heart disease	○	○	
Arthritis	○	○		Kidney disease	○	○	
Cancer	○	○		Psychiatric disease	○	○	
Diabetes	○	○		Tuberculosis	○	○	
Epilepsy	○	○		Other	○	○	
High blood pressure	○	○					

Please explain any yes answers: _____

_____

_____