Notre Dame de Namur University
Health and Wellness

CONFIDENTIAL INFORMATION

NOTE: This Medical Evaluation Form will be filed with the Health and Wellness Department to better assist students when visiting the campus nurse.

Name_____
LAST FIRST MIDDLE

Student ID#_____

Home Address_____
STREET CITY STATE ZIP CODE

Date of Birth _____Student Cell Phone _____

Home Phone _____Parent Cell Phone_____

Emergency Contact_____

Emergency Phone _____

List any medications, including dosages, that you are now taking. Include prescriptions, over-the-counter medication, performance enhancers/supplements, and vitamins.

_____
_____

Yes No

__ __ Allergy or severe reaction to any medication (specify type of reaction):_____
_____

___ ___ Any other allergy, or severe reaction to insect, bees, wasps or food (specify type of reaction)
_____

Current Weight_____ Height_____

Please check whether you have ever had any of the following conditions. If YES, provide approximate date(s) and details.

Yes No

__ __ Anemia
__ __ Allergies, hay fever
__ __ Asthma
__ __ Diabetes
__ __ Kidney or bladder problem
__ __ Drug or alcohol dependency
__ __ Significant illness/injury
__ __ Fainting or passing out
__ __ Gynecologic disorder
__ __ Head injury, concussion
__ __ Hernia

Yes No

__ __ High blood pressure
__ __ Irregular menses
__ __ Irregular heartbeat or extra beats
__ __ Mononucleosis (Mono)
__ __ Physical disability
__ __ Thyroid disorder
__ __ Depression or anxiety
__ __ Epilepsy or seizures
__ __ Ulcers, stomach problem, colitis
__ __ Past surgeries
__ __ Other

Explanation:_____
_____
_____
_____
_____

Check whether family members have had any of the following conditions.

No Yes (explain)

__ __ Diabetes _____
__ __ History of heart problems_____
__ __ High blood pressure _____
__ __ Sudden death before age 50 _____
__ __ Other significant family illness, please describe_____

Student Signature: _____Date_____