University of the Ozarks
415 N. College Avenue Clarksville, Arkansas 72830

HEALTH HISTORY Date: _____

This record will be confidentially maintained by the university for your personal safety and that of the Ozarks community. The most accurate information you can furnish is essential. Please consider these questions carefully. Ozarks staff may review, ask you to update, or call you to discuss information as needed and where it applies to Ozarks programming. Your detailed comments will expedite our review. This does not affect your admission to the university.

PARTICIPANT

Last Name: _____ **Middle Name:** _____ **First Name:** _____
Date of Birth: _____ **Phone Number:** _____ **Email:** _____
Age: _____ **Height:**_____ **Weight:** _____ ❑ Male ❑ Female ❑ Ozarks Student ❑ Faculty/Staff ❑ Community
Address: _____ **City/State:** _____ **Zip:** _____

MEDICAL HISTORY

A. **Have you ever experienced any of the following:** **If any are checked - please explain:**
- ❑ altitude sickness
- ❑ heart problems
- ❑ hay fever
- ❑ stroke
- ❑ other _____

B. **Do you have any allergies to the following:** **If any are checked - please explain:**
- ❑ insects [bees, spiders, etc…]
- ❑ foods
- ❑ sun
- ❑ plants
- ❑ other _____

C. **Are you allergic to any medications? ❑ YES ❑ NO**

If yes, please list:

D. **Are you currently taking any medications?** ❑ YES ❑ NO
If yes - for what conditions? _____

Please list medications, dosage, side effects/restrictions:

E. **Water may be disinfected with iodine. Do you have medical problems with iodine?** ❑ YES ❑ NO

F. **Do you have any restrictions for medical reasons?** ❑ YES ❑ NO **If yes, please list/explain:** _____

G. **Diet considerations:** ❑ will eat anything ❑ vegetarian ❑ vegan ❑ I will not/cannot eat: _____

H. **Do you have or have a history of:**
- ❑ Respiratory Problems
  Asthma? ❑ YES ❑ NO **Triggers**: _____
  Helped with inhaler? ❑ YES ❑ NO
- ❑ Hospitalization
- ❑ Gastrointestinal Disturbances
- ❑ Diabetes
- ❑ Hypoglycemia (Low Blood Sugar)
- ❑ Bleeding, DVT, Blood Disorders
- ❑ Hepatitis or Other Liver Disease
- ❑ Neurological Problems
  Epilepsy? ❑ YES ❑ NO
- ❑ Seizures
- ❑ Thyroid?
- ❑ Dizziness or fainting episodes?
- ❑ Migraines?
  Medications, frequency, are they debilitating? _____
- ❑ Treatment/medication for menstrual cramps?
- ❑ Disorders of the urinary or reproductive tract?
- ❑ Any disease?
- ❑ Hypertension
- ❑ Chest Pain? Cardiac problems? ❑ YES ❑ NO
- ❑ Heat Stroke or heat related illness?
- ❑ Frostbite or Raynaud's Syndrome?
- ❑ Heat Stroke or heat related illness?

For H. describe frequency, date of last episode and severity: _____

I. **Do you have any physical, cognitive, sensory or emotional condition that would require a special teaching environment?** ❑ YES ❑ NO If yes, please describe how the condition affects you (please include a statement from your physician):

J. **Are you pregnant?** ❑ YES ❑ NO **If yes – how far along?** _____

K. **Do you see a medical or physical specialist of any kind?** ❑ YES ❑ NO
If "yes" please specify the issue(s) (please include a statement from your physician):

L. **Have you had treatment, counseling or hospitalization with a mental health professional?**
❑ YES ❑ NO If "yes" please specify the issue(s):_____
_____

M. **Are you currently in treatment or counseling?** ❑ YES ❑ NO
If "yes" please specify the reasons for treatment or counseling:
❑ suicide
❑ ADD/ADHD
❑ substance abuse/chemical dependency
❑ family issues/divorce
❑ eating disorder (anorexia/bulimia)
❑ depression
❑ academic/career
❑ other _____
Please provide specific dates and details of counseling history and medications that were prescribed:
_____
_____

N. **Do you currently have or have a history of the following injuries *(including sprains and/or surgery)*:**
❑ Knee, hip or ankle?
❑ Shoulder, arm or back?
❑ Joint problems?
❑ Is there full Range of Motion (ROM)?
Full Strength? ❑ YES ❑ NO
❑ Head Injury?
Loss of consciousness? ❑ YES ❑ NO
Type of injury or surgery? When did the injury or surgery occur? _____
_____
_____
What is the most rigorous activity participated in since the injury/surgery: _____
_____

O. **Please rate yourself in the following areas.** [Check the description which best fits your skill level or experience]
1. Do you smoke? ❑ YES ❑ NO
If yes – how much?/how long? _____
2. Are you overweight? ❑ YES ❑ NO
If yes – how much?/how long? _____
3. Swimming ability:
❑ none ❑ beginner ❑ intermediate ❑ advanced
4. Do you exercise regularly? ❑ YES ❑ NO
Activity(ies): _____
_____
❑ Easy ❑ Moderate ❑ Competitive
5. Fitness level:
❑ fair ❑ good ❑ excellent

Contact Information:
Name of Nearest Relative (or Emergency Contact residing in U.S.): _____
Address: _____
City/State/Zip: _____
Home Phone: _____ Work Phone: _____

Physician's Name: _____
Address: _____
City/State/Zip: _____
Emergency Phone: _____ Work Phone: _____

Dentist's Name: _____
Address: _____
City/State/Zip: _____
Emergency Phone: _____ Work Phone: _____

Health Insurance Company: _____
Policy #: _____ Phone: _____