Lehigh University Health & Wellness Center
HEALTH FORM (Complete in Blue/Black Ink)

UNDERGRADUATE

*Fall Semester Entry – please complete/return by June 30th
*Spring Semester Entry – please complete/return by January 1st

Please Attach Your 2"x 2" Photo Here

Last Name – First Name – Middle | Birth date (MM/DD/YY) | Gender

Lehigh ID # (LIN #) | Expected Year of Graduation | Cell Phone

Home Address | City | State/Province | Country (if not U.S.) | Zip Code

Parent/Guardian Name | Occupation

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IMPORTANT: Students must complete the emergency contact form on the evoLUtion:1 tab of the campus portal.

GENERAL MEDICAL HEALTH HISTORY

ALLERGIES TO:			**GASTROINTESTINAL/URINARY TRACT**		
Medication: _____	YES	NO	IBS/GERD	YES	NO
Food: _____	YES	NO	Crohn's/Colitis	YES	NO
Environment: _____	YES	NO	Kidney/Bladder	YES	NO
Do you carry an Epi-Pen?	YES	NO	GYN/Testicular	YES	NO
CARDIOVASCULAR			**PSYCHOLOGICAL/MENTAL HEALTH**		
Fainting	YES	NO	Depression	YES	NO
High Blood Pressure	YES	NO	Anxiety	YES	NO
Palpitations	YES	NO	ADHD/Learning Disorder	YES	NO
Heart Murmur	YES	NO	Eating Disorder	YES	NO
RESPIRATORY			**NEUROLOGICAL**		
Asthma	YES	NO	Seizures	YES	NO
Use of Inhalers	YES	NO	Headaches/Migraines	YES	NO
INFECTIOUS DISEASES			**SURGICAL**		
Mononucleosis	YES	NO	Tonsils/Adenoids	YES	NO
Chicken Pox/Varicella	YES	NO	Appendix	YES	NO
ENDOCRINE/AUTOIMMUNE			**FAMILY HISTORY** (circle all that apply)		
Diabetes	YES	NO	High Blood Pressure	Heart Disease	
Thyroid	YES	NO	Sudden Cardiac Death	Diabetes	
Arthritis	YES	NO	Cancer	Cerebral Aneurysm	

If YES to any of the above, OR conditions not listed, please describe:

Current Medications (name & dosage), including supplements and non-prescription medications:

The Lehigh University Health Center Privacy Notice is available at: http://www.lehigh.edu/health/mission.shtml#privacy
If you would like to receive a paper copy please contact the Health & Wellness Center at 610-758-3870 for a mailed copy.
By my signature below, I acknowledge that I have read and understand the LUHC Privacy Notice.

Student Signature | Date

Last Name, First Name: _____ LIN#: _____

YOUR HEALTH CARE PROVIDER MUST SIGN THE EXAM AND THE IMMUNIZATION RECORD.
THE HEALTH CARE PROVIDER MAY NOT BE A RELATIVE OF THE STUDENT.

PHYSICAL EXAM

Date of Exam_____ Ht _____ Wt _____ BP _____ BMI_____ Pulse _____

Vision: R _____/_____ L _____/_____ Corrected? Yes No Hearing: R_____ L_____

	Normal	Abnormal - Describe
Skin		
Head and scalp		
Eyes		
Ears / Hearing		
Mouth, Nose, Throat		
Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Musculoskeletal		
Neurologic		
Psychological/Affect		

PLEASE NOTE: The NCAA requires ALL incoming varsity athletes to have a physical examination within 6 months of participation in any weight training or conditioning activity at Lehigh *and* a Sickle Cell Trait (SCT) blood test. Lehigh Varsity Sport (if applicable) _____

1) This student has been tested for sickle cell trait. Please provide documentation of test results. □ YES □ NO

2) This student is medically cleared for sports participation: □ YES □ NO

Health Care Provider's name _____

Address _____

_____

Phone _____ **Fax**_____

Provider Signature _____

Date _____

Return to: Lehigh University
Health & Wellness Center
36 University Drive
Bethlehem, PA 18015-3061
Phone: 610-758-3870
Fax: 610-758-5833