

## Student Health Information Questionnaire

In order to respond to your needs and provide you with essential services, you are required to complete this health questionnaire. This form will become a part of your health record and is protected under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  Male  Female  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Country of Birth \_\_\_\_\_ Marital Status:  Married  Single  Divorced

### Emergency Contacts

Name(s) \_\_\_\_\_ Relationship \_\_\_\_\_ Day Phone \_\_\_\_\_  
 Evening Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Name(s) \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Physician Information

Name \_\_\_\_\_ Telephone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Illnesses and Health Conditions (which you currently have or for which you have been treated)

<input type="checkbox"/> Allergic Reactions/Specify _____	<input type="checkbox"/> Eating Disorders _____	<input type="checkbox"/> Kidney Problems/Specify _____
<input type="checkbox"/> Anemia _____	<input type="checkbox"/> Emotional Problems/Specify _____	<input type="checkbox"/> Seizures _____
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Epilepsy _____	<input type="checkbox"/> Substance Abuse _____
<input type="checkbox"/> Cancer/Specify type _____	<input type="checkbox"/> Food Allergies/Specify _____	<input type="checkbox"/> Surgery/Specify _____
<input type="checkbox"/> Colitis _____	<input type="checkbox"/> Hay Fever _____	<input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> Depression _____	<input type="checkbox"/> Heart Problems/Specify _____	<input type="checkbox"/> Ulcer/Specify _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Other/Specify _____
<input type="checkbox"/> Drug Allergies/Specify _____		

If you are on regular medication, please indicate the name and dosage: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please fax this completed form to 501-450-3843 or mail to:  
 Hendrix College Office of Admission · 1600 Washington Avenue · Conway, AR 72032-3080