

Georgia Military College Student Health Services
201 E. Greene Street Milledgeville GA 31061-3398
Phone:(478) 445-2713 Fax:(478) 445-1928

Health Questionnaire

Expected term of entry: Fall Winter Spring Summer Year:_____

Name_____ Cell Phone_____

Birth-date_____ Social Security #_____

Home address_____

City/State/Zip_____ Phone_____

Persons to contact in the event of an emergency:

Name_____ Relationship_____

Address_____

City/State/Zip_____

Phone_____ Work_____ Cell_____

Name_____ Relationship_____

Address_____

City/State/Zip_____

Phone_____ Work_____ Cell_____

INSURANCE INFORMATION:

Note: A mandatory accident group insurance policy is purchased with the student insurance fee. This is a secondary policy limited to accidental injuries and does not cover illnesses. Students are encouraged to have a personal health insurance policy.

Insurance Company Name:_____

Address_____ **Phone**_____

Name of Policy-holder:_____ **ID#**_____

Policy #_____ **Group #**_____

Please attach a copy of insurance card (front and back).

ALLERGIES	Yes	No	If yes, give details:
Medication	_____	_____	_____
Food	_____	_____	_____
Insect	_____	_____	_____
Pollen	_____	_____	_____
Other	_____	_____	_____

Name _____

Medical History: Check if you have had any of the following

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Chicken pox |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Orthopedic injury/condition | <input type="checkbox"/> Other |

Additional information: _____

Have you ever received psychiatric treatment or medication? Yes No

If yes, please give details:

Have you ever been hospitalized or had surgery? Yes No

If yes, please give dates/reasons:

Are you currently under the care of a doctor? Yes No

If yes, please explain:

Who is your current health care provider?

Name _____
Address _____
City/State/Zip _____ Phone _____

Are you currently taking any medications? Yes No

If yes, please list:

Do you have any activity/exercise restrictions? Yes No

If yes, please explain:

Note: A written statement from your doctor must be submitted to Health Services for exemption from physical training exercises.