

Last Name	First	Middle
Professor or Section #	Date of Birth	Age
Phone	Email	

**Family History** PLEASE CHECK BOXES THAT APPLY

I am adopted

	My Father	My Mother	My Children	My Siblings	Father's Parents	Mother's Parents
<b>Adopted</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Bleeding Disorder</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Death</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Diabetes</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Epilepsy/Convulsions</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>High Blood Pressure</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Mental Illness</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Obesity</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Stroke</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Tuberculosis</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Present or Previous Medical Problems**

Please check boxes that apply.

- |  |  |
|--|--|
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Heart murmur              |
| <input type="checkbox"/> Anorexia                      | <input type="checkbox"/> Heart valve problem       |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Hepatitis-A               |
| <input type="checkbox"/> Bleeding disorder             | <input type="checkbox"/> Hepatitis-B               |
| <input type="checkbox"/> Blindness partial or complete | <input type="checkbox"/> High blood pressure       |
| <input type="checkbox"/> Bulimia                       | <input type="checkbox"/> Hypoglycemia              |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Mono in past 6 mos.       |
| <input type="checkbox"/> Chlamydia                     | <input type="checkbox"/> Kidney stone or infection |
| <input type="checkbox"/> Colitis, ulcerative           | <input type="checkbox"/> Migraine headaches        |
| <input type="checkbox"/> Cystic Fibrosis               | <input type="checkbox"/> Pneumonia                 |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Polyps in colon           |
| <input type="checkbox"/> Depression                    | <input type="checkbox"/> Positive HIV              |
| <input type="checkbox"/> Epilepsy                      | <input type="checkbox"/> Rheumatic fever           |
| <input type="checkbox"/> Glaucoma                      | <input type="checkbox"/> Thyroid problems          |
| <input type="checkbox"/> Hearing loss                  | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Heart, enlarged               | <input type="checkbox"/> Stomach ulcers            |

Surgeries

\_\_\_\_\_

\_\_\_\_\_

Daily Medicines

\_\_\_\_\_

\_\_\_\_\_

Sports Injuries (within last 3 mos.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Weight \_\_\_\_\_

Height \_\_\_\_\_

**Cornerstone University 2008-09**

Check all that apply:

- College/Spouse       Faculty/Spouse       PGS  
 Seminary/Spouse       Staff/Spouse       Foundations of Wellness Class

**Wellness Assessment Questions.** Circle the appropriate answer.

- |     |    |   |
|-----|----|---|
| Yes | No | Do you exercise on a regular basis at least 3 times a week?   |
| Yes | No | Is this exercise done vigorously for at least 15-30 minutes each time?<br>What types of exercise do you do? _____ |
| Yes | No | Do you eat breakfast on a regular basis?  |
| Yes | No | Do you eat fresh fruits and vegetables?   |
| Yes | No | Do you choose lower fat content foods?  |
| Yes | No | Do you have at least 2 meals per day plus snacks, fruits, etc.?   |
| Yes | No | Are you having difficulty falling asleep or sleeping at least 6-7 hours per night?                                |
| Yes | No | Do you become angry easily?   |
| Yes | No | Are you often depressed about life?   |
| Yes | No | Do you feel positive about college or your job?   |
| Yes | No | Do you get along well with others?  |
| Yes | No | Do you laugh easily?  |
| Yes | No | Do you have close friends, relatives, or others you can talk to about personal matters and for help when needed?  |
| Yes | No | Do you have hobbies or participate in group activities (as in church or community organizations) that you enjoy?  |
| Yes | No | Do you use alcohol or drugs as a way of handling stressful situations.  |
| Yes | No | Do you smoke cigarettes, pipes, cigars, or use chewing tobacco?   |
| Yes | No | Are you experiencing a healthy growing relationship with the Lord Jesus Christ?                                   |
| Yes | No | Do you engage in any self destructive behaviors?  |
| Yes | No | Are you able to create time to relax?   |

**For Office Use Only**

Blood Pressure: \_\_\_\_\_

Body Mass Index (BMI): \_\_\_\_\_

Healthy Weight BMI is 18.5 to 24.9

**Consultation:**

\_\_\_\_\_ You're doing great! Keep up the good work!!

\_\_\_\_\_ Currently no obvious problems, but in future years your family history may be more significant with your health!

\_\_\_\_\_ Due to your responses above, you may wish to consider counseling. Our campus counseling service is available to you free. Call Ext. 1441 for appt.

\_\_\_\_\_ Please see your family doctor.

\_\_\_\_\_ Make appointment with our Health Care provider to discuss your results (free).

\_\_\_\_\_ Immediate contact has been attempted due to your abnormal laboratory results. Please contact us at ext. 1441 if we have not reached you.

\_\_\_\_\_       CM, PA-C

I authorize release of this information for research purposes. **Sign here** \_\_\_\_\_