LEE UNIVERSITY
Health Services

P.O. Box 3450
Phone: 423-614-8430

1120 N. Ocoee Street

Cleveland, TN 37320-3450
Fax: 423-464-4452

REPORT OF MEDICAL HISTORY

_____ _____ _____ _____
Last Name First Name Middle Colleague ID Number

If Living on Campus:

P.O. Box # _____
Dorm: _____ Room Number: _____
Cell Number: _____
Email Address: _____

If Living Off Campus:

Address: _____
_____
Cell Number: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ Other

In Case of Emergency Notify: _____ Relationship: _____
Parent or Guardian

Their Address: _____ Phone Numbers: Home (___) _____
(Street Address)

Work (___) _____

_____ Cell (___) _____
(City, State and Zip Code)

PERSONAL MEDICAL HISTORY: **VERY IMPORTANT:** Please answer all questions. Comment on the back on all positive answers or have your family physician send a summary of your medical history to the Lee University Health Clinic.

ALLERGIES: (PLEASE LIST ALL AND DESCRIBE REACTION)

DRUGS: _____
FOODS: _____
OTHERS: _____

HAVE YOU HAD OR CURRENTLY HAVE:		YES	NO
1.	Eye Trouble	☐	☐
2.	Ear, Nose, Throat Trouble	☐	☐
3.	Frequent or Severe Headaches	☐	☐
4.	Epilepsy/Convulsions	☐	☐
5.	Asthma	☐	☐
6.	Fainting/Passing Out	☐	☐
7.	Frequent or Severe Respiratory Infections	☐	☐
8.	High Blood Pressure	☐	☐
9.	Heart Murmur/Heart Problems	☐	☐

Patient/Student Name: _____ **DOB:** _____

		YES	NO
10.	Hepatitis or Jaundice	☐	☐
11.	Thyroid Problems	☐	☐
12.	Kidney Disease	☐	☐
13.	Bone/Joint Problems	☐	☐
14.	Stomach/Intestinal Trouble	☐	☐
15.	Anemia	☐	☐
16.	Diabetes	☐	☐
17.	Infectious Mononucleosis	☐	☐
18.	Thoughts of Self-Harm or Harm to Others	☐	☐
19.	Suicidal Thoughts or Suicide Attempts	☐	☐
20.	History of Substance Abuse	☐	☐
21.	Other:	☐	☐

If you answered yes to questions 1 – 20, please explain: _____

_____

_____

_____

_____

_____

A. Do you have any health problem and/or are receiving treatment (medications) that would require periodic evaluation?
Please explain: ☐**YES** ☐**NO**

B. Have you had any medical illness, injury, operation, or been hospitalized?
Please explain: ☐**YES** ☐**NO**

C. Have you ever been hospitalized for a mental or psychiatric illness?
Please explain: ☐**YES** ☐**NO**

D. Do you have any physical handicaps or disabilities that may restrict your physical activity?
Please explain: ☐**YES** ☐**NO**

Patient/Student Name: _____ **DOB:** _____

E. Are you taking psychotropic medications (i.e. Medications prescribed for mental health or behavioral conditions)? □ **YES** □**NO**

If yes, please list name, dosage, and frequency of medication.

F. Do you have family members with chronic medical conditions?

Please check:

Heart Disease □ High Blood Pressure □ Diabetes
Cancer □ Blood Disorder □ Seizure Disorders

Other: _____
_____
_____
_____

I feel that I have answered these questions to the best of my knowledge:

I do hereby give my permission for Lee University Health Clinic to release information from my physical to the appropriate persons.
Signature of Student: _____ **Date:** _____

Patient/Student Name: _____ **DOB:** _____

THIS PAGE IS FOR OFFICE USE ONLY:

PHYSICAL EXAMINATION

NAME: _____ BIRTHDATE: _____ COUNTRY VISITING _____

HEIGHT: _____ WEIGHT: _____ PULSE: _____ BLOOD PRESSURE _____

BMI: _____ HEMOGLOBIN: _____

VISION: Without/With Glasses: Right: _____ Left: _____ Color Vision: _____

URINALYSIS: Sp.Grav. _____ Alb _____ Sugar _____ Micro _____

Pre-Physical Date: _____ Nurse Signature: _____

CHECK (√) if normal: Mark (X) if abnormal:

HEAD-NECK	□	CHEST	□	ABDOMEN	□
GLANDS	□	LUNGS	□	GENITO-URINARY	□
MOUTH-THROAT	□	HEART	□	SKIN-SCARS	□
NOSE	□	VESSELS	□	EXTREMITIES	□
EYES	□	JOINTS	□	SPINE-MOTION	□
EARS	□	PHSYCHIATRIC	□	NEUROLOGICAL	□
TEETH-GUMS	□				

DETAIL ABNORMAL FINDINGS:

LIMITATIONS:

Signature of Provider: _____ Print Name: _____

Date of Exam: _____ Phone: _____

LEE UNIVERSITY

HEALTH SERVICES: MENTAL HEALTH QUESTIONAIRE

NAME:_____ **DOB:**_____

This questionnaire has been designed to facilitate your physical. As part of your overall check-up, the medical staff will review this sheet and discuss any potential problems you may be experiencing. We appreciate you completing the questionnaire.

Please check the appropriate column for any condition which may apply.

CONDITION	CURRENT CONDITION	PAST CONDITION	NO HISTORY OF CONDITION
Anorexia			
Anxiety			
Bulimia			
Depression			
Mood Swings			
Panic Attacks			
Phobias			
Psychotic Symptoms			
Substance Abuse			
Suicidal Attempts			
Suicidal Thoughts			
Uncontrolled Anger			

1. Have you ever received treatment for any emotional, mental, or behavioral problem or disorder?

   Please explain: □YES □NO

2. Have you ever interrupted school or work as a result of mental or emotional illness?
   Please explain: □YES □NO

3. Please list relevant concerns that relate to your emotional health that may be beneficial to the medical staff to be aware of. Comment on any condition that may limit your activities.

I have answered the items in this questionnaire accurately. I understand that this form will be held confidential.

Signature:_____ **Date:**_____

NAME:_____ **DOB:**_____ **Date:**_____

Please indicate if and when you have had the following experiences:	**How many times?**	**The last time (most recent)?**
Been hospitalized for mental health concerns	Never 1 time 2-3 times 4-5 times More than 5 times	Never Within the last 2 weeks Within the last month Within the last year Within the last 1-5 years More than 5 years ago
Seriously considered attempting suicide	Never 1 time 2-3 times 4-5 times More than 5 times	Never Within the last 2 weeks Within the last month Within the last year Within the last 1-5 years More than 5 years ago
Made a suicide attempt	Never 1 time 2-3 times 4-5 times More than 5 times	Never Within the last 2 weeks Within the last month Within the last year Within the last 1-5 years More than 5 years ago
Considered causing serious physical injury to another person	Never 1 time 2-3 times 4-5 times More than 5 times	Never Within the last 2 weeks Within the last month Within the last year Within the last 1-5 years More than 5 years ago
Intentionally caused serious physical injury to another person	Never 1 time 2-3 times 4-5 times More than 5 times	Never Within the last 2 weeks Within the last month Within the last year Within the last 1-5 years More than 5 years ago
Experienced abuse, neglect, stalking, trauma, etc. (e.g. sexual, physical, verbal/emotional) AND Such experience(s) are likely to have impact on your sense of safety in relationships, settings, or experiences associated with your cross-cultural trip. (Only if "yes" to both having such experience and potential trip impact, indicate frequency and recency of the traumatic experiences in the boxes to the right.)	Never 1 time 2-3 times 4-5 times More than 5 times	Never Within the last 2 weeks Within the last month Within the last year Within the last 1-5 years More than 5 years ago
Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, or authority figure)	Never 1 time 2-3 times 4-5 times More than 5 times	Never Within the last 2 weeks Within the last month Within the last year Within the last 1-5 years More than 5 years ago
Experienced a traumatic event that caused you to feel intense fear, helplessness, or horror	Never 1 time 2-3 times 4-5 times More than 5 times	Never Within the last 2 weeks Within the last month Within the last year Within the last 1-5 years More than 5 years ago

Reviewed by: _____ **Date:** _____

NAME:_____ **DOB:**_____ **Date:**_____

YES	NO	Relevant Current/Recent Mental Health Information
		Are you presently engaged in mental health counseling/therapy?
		If yes above, indicate yes or no regarding whether it is true that… EITHER a) You have discussed and planned with your therapist that participation in this trip is psychologically appropriate for you at this time b) AND you have identified sufficient resources to function without counseling/therapy during this trip, OR c) You have not discussed this trip with your therapist BUT you are confident that you have independently identified sufficient resources to function without counseling/therapy during this trip.
		Are you taking psychotropic medications (i.e. Medications prescribed for mental health or behavioral conditions)?
		If yes above, please list name, dosage, and frequency of medication.
YES	NO	Relevant Current/Recent Mental Health Information
		Have you made yourself familiar with the list of potential psychological (mental health) demands or risk factors associated with your particular global perspectives trip?
		Do you believe there are aspects of this trip or aspects of your recent/current mental health functioning that may impact safety (for yourself or others) or may impact your capacity to successfully engage in the expectations and experiences of your global perspectives trip? (If yes, explain below & continue. If no, skip remainder of this table.)
		Have you made your trip leader aware?
		Have you discussed/created a mutually-agreed-upon plan with your trip leader (and any other appropriate party)?

YES	NO	**Recent Experiences** Please indicate whether you have experienced any of the following *within the past (1) month*.
		Heard or seen things that do not exist.
		Been without sleep or food for 2 consecutive days or more.
		Experienced uncontrollable despair, anxiety, or anger.
		Had a severe reaction to psychiatric medication.

Reviewed by: _____ **Date:** _____