

College of Lake County
19351 W. Washington Street
Grayslake, IL 60030

STUDENT HEALTH RECORD
CONFIDENTIAL
PLEASE PRINT CLEARLY IN BLACK INK ONLY

Health Services
Phone: 847-543-2064
Fax: 847-543-3064

Name _____ Birth Date ____/____/____
Last First Middle Initial
CLC ID # _____ Gender _____ Veteran Program _____
Telephone _____ Email Address _____
Primary Secondary
Address _____
Street City State Zip Code

Emergency Contact Relationship (circle one) Spouse/Guardian/parent/Other _____ Name _____ Contact Number(s) _____

ROUTINE MEDICATIONS: (PRESCRIBED AND/OR OVER THE COUNTER)

MEDICATION ALLERGIES: Yes ___ No ___ **FOOD/ENVIRONMENTAL ALLERGIES:** Yes ___ No ___

If yes, please list _____

FAMILY HISTORY of health problems (heart disease, diabetes, cancer, etc. - includes parents, grandparents, siblings, children - be specific): _____

HOSPITALIZATIONS/SURGERIES (type and date) _____

SOCIAL HISTORY	No	Yes*	
Tobacco Use			
Exercise			
Alcohol/Drugs			

Have you ever had, or do you now have any of the following:

	No	Yes*	*Explain yes answers
Headaches/migraines			
Eye disease			
Ear, nose and throat diseases			
Heart problems or high blood pressure			
Breathing problems			
Abdominal pain or liver disease			
Back Pain			
Cancer			
Diabetes			
Seizures			
Anxiety/depression/abuse			
• Is this a current concern?			
• Are you currently receiving treatment for this concern?			
• Are you interested in college or community resources for this concern?			
Tuberculosis			
Rheumatic fever			
Bone or joint problems			

The above information is accurate _____
Signature Date