

STONE LABORATORY

Medical History and Consent Form 2009

Complete and sign this and the **Housing Contract** located on page 2.

Personal History: Do you have or have you been treated for any of the following? (*Please check*)

<input type="checkbox"/> Acne	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Pelvic infection	<input type="checkbox"/> Tonsillitis	Surgical Operations For:	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Digestive Disorder	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tuberculosis		<input type="checkbox"/> Appendectomy
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Polio	<input type="checkbox"/> Urinary Tract Infection		<input type="checkbox"/> Back Injury
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Drug Dependency	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Prostatitis	<input type="checkbox"/> Viral Hepatitis		<input type="checkbox"/> Breast Biopsy
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Malaria	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Weight Control (Laxatives)		<input type="checkbox"/> Broken Bone(s)
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> (Anorexia/Bulimia)	<input type="checkbox"/> Measles (Rubella)	<input type="checkbox"/> Recurrent Headaches	<input type="checkbox"/> Worry/Nervousness		<input type="checkbox"/> Cosmetic Surgery
<input type="checkbox"/> Cancer	<input type="checkbox"/> Emotional/Mental Illness	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Irregular/Painful Menstrual Cycles		<input type="checkbox"/> Gynecological Surgery
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> German Measles (Rubella)	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Seizure Disorder			<input type="checkbox"/> Hernia
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Sinusitis	Other _____		<input type="checkbox"/> Mole Removal
<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Hearing Disorder	<input type="checkbox"/> Mumps	<input type="checkbox"/> Sexually Transmitted Disease _____			<input type="checkbox"/> Oral Surgery
<input type="checkbox"/> Chronic Kidney condition	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Systemic Lupus _____			<input type="checkbox"/> Orthopedic Surgery
<input type="checkbox"/> Colitis	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Obesity	<input type="checkbox"/> Thyroid Disorder _____			<input type="checkbox"/> Pilonidal Cyst
<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Peptic Ulcer				<input type="checkbox"/> Tonsils/Adenoids

Have you ever been hospitalized? Yes No. If yes, explain:

Do you have any physical limitations or permanent disability? Yes No. If yes, explain:

Allergies: Are you allergic to any of the following?

Aspirin	Yes	No
Ampicillin	Yes	No
Penicillin	Yes	No
Sulfa	Yes	No

Other Medication:

List any other allergies, bee sting, food, other:

Family History: Have any of your family members had the following? (*Please Check*)

	PARENTS	OTHER RELATIVE
Arthritis	_____	_____
Anemia	_____	_____
Asthma	_____	_____
Alcoholism	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
Drug Addiction	_____	_____
Emotional/Mental Illness	_____	_____
Heart Disease	_____	_____
Kidney Disease	_____	_____
Stroke	_____	_____

Medication Usage: Which of the following do you take on a regular basis? (*Explain*)

<input type="checkbox"/> Antihistamines	<input type="checkbox"/> Cortisone Inhaler	<input type="checkbox"/> Nasal Spray
<input type="checkbox"/> Antacid	<input type="checkbox"/> Digitalis	<input type="checkbox"/> Pain Medication
<input type="checkbox"/> Arthritis Medication	<input type="checkbox"/> Diuretic	<input type="checkbox"/> Sleeping Pills
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Epilepsy Medication	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Asthma medication	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Insulin	<input type="checkbox"/> Tranquilizers
<input type="checkbox"/> Antidepressant	<input type="checkbox"/> Iron	<input type="checkbox"/> *Other
<input type="checkbox"/> Birth Control Pills/IUD	<input type="checkbox"/> Laxative	

*Name and dosage of medication(s)

Miscellaneous Information

	OFTEN	SOMETIMES	NEVER
Do you smoke cigarettes?	_____	_____	_____
Do you use snuff or chew tobacco?	_____	_____	_____
Do you drink alcohol?	_____	_____	_____

I give my consent for any medical treatment that I or my child, (print name of program participant) _____, might require while in the 2009 Stone Lab program. I authorize and request The Ohio State University Stone Laboratory personnel to refer me/or my child to duly licensed medical authority when indicated, including transfer to hospitals. I hereby grant authority to a qualified physician to render such medical treatment as the physician deems necessary under the circumstances. I have medical coverage for myself or my child through, Company Name: _____.

In the event of an emergency, please contact:

Name _____

Phone# (_____) _____

or

Name _____

Phone# (_____) _____

My/ or my child's regular physician is

Dr. _____

Address: _____

Phone# (_____) _____

If the participant is under age 18, a parent or legal guardian must sign this form.

Participant's Full Name (please print) _____

Participant's Signature X _____

Parent or Legal Guardian's Full Name (please print) _____

Parent or Legal Guardian's Signature X _____

Date _____

STONE LABORATORY

Housing Contract 2009

Complete and sign this and the
Medical History and Consent
Form located on page 1.

Please complete all information.

Name _____

Street _____ Phone# () _____

City _____ State _____ Zip _____

Date of Birth / / Age _____ Sex: Male _____ or Female _____

Check all that apply

_____ Student _____ Non-Credit Workshop Participant _____ Teaching Assistant

_____ Researcher _____ Laboratory Employee

*In signing this contract, I agree to abide by the Community Standards of Conduct as published
in the Stone Laboratory Handbook while enrolled in the 2009 program.*

If the participant is under age 18, a parent or legal guardian must sign this form.

Participant's Full Name (please print) _____

Participant's Signature X _____

Parent or Legal Guardian's
Full Name (please print) _____

Parent or Legal Guardian's Signature X _____

Date _____

RETURN THIS APPLICATION BY THE APPROPRIATE DEADLINE TO:

Arleen Pineda
Stone Laboratory
1314 Kinnear Rd.
Columbus, OH 43212

Tel: 614.292.8949
Email: pineda.2@osu.edu
Fax: 614.292.4364

