Monroe Community College
STATE UNIVERSITY OF NEW YORK

# Student Health History Form

Name: _____ M00#: Today's Date: _____

Preferred Name: _____ Gender: _____ DOB: _____

Cell Phone #: _____ Residence Hall: _____

Emergency Contact: Relationship: _____ Phone: _____

Primary Doctor Name: _____ Primary Doctor Phone: _____

Health Insurance Carrier: ID Number: _____

For Students under 18: I give my consent for Health Services, or its' designees, to provide medical treatment to my son/daughter. Parent/Guardian Signature _____ Date: _____

## Allergies

Please list all allergies (such as to drugs, bees, latex, etc.)

Substance: _____ Reaction: _____ Treatment: _____

Substance: _____ Reaction: _____ Treatment: _____

Substance: _____ Reaction: _____ Treatment: _____

Substance: _____ Reaction: _____ Treatment: _____

## Medicines

Please list all you use, including over the counter medicines

Medicine: _____ Dose: _____ Times/Day: _____ Used For: _____

Medicine: _____ Dose: _____ Times/Day: _____ Used For: _____

Medicine: _____ Dose: _____ Times/Day: _____ Used For: _____

Medicine: _____ Dose: _____ Times/Day: _____ Used For: _____

## Confidential Health History

*Mark each that apply, add details or more information below.*

- ☐ ADD
- ☐ ADHD
- ☐ Alcohol use in past year
- ☐ Anxiety
- ☐ Asthma
- ☐ Bipolar diagnosis
- ☐ Bladder infections
- ☐ Bone problems
- ☐ Colitis
- ☐ Concussions/ Head injuries
- ☐ Depression
- ☐ Drug use or addiction
- ☐ Eating disorder
- ☐ Eczema
- ☐ Experienced abuse/trauma
- ☐ Eye/vision problems
- ☐ Hearing impaired/deaf
- ☐ Heart problems
- ☐ High blood pressure
- ☐ History of fainting
- ☐ History of cutting skin
- ☐ In recovery from substance use disorder
- ☐ Kidney problems
- ☐ Marijuana use in past year
- ☐ Migraines
- ☐ Neurological issue
- ☐ Psoriasis
- ☐ PTSD
- ☐ Seizures- petit/grand/focal
- ☐ Last seizure: _____
- ☐ Severe menstrual cramps
- ☐ Stomach issues
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Tobacco use
- ☐ Trouble sleeping
- ☐ Tuberculosis
- ☐ Use anything else to get "high" in past year

More Information: _____

Hospitalizations: _____

Surgeries: _____

I attest to the truthfulness of the above statements and that I am free from habituation or addiction to depressants, stimulants, narcotics and other behavior altering substances.

Student Signature: _____ Date: _____