COLGATE UNIVERSITY STUDENT HEALTH SERVICES
13 Oak Drive, Hamilton, NY 13346 **Phone:** 315-228-7750 **Fax: 315-228-6823**
studenthealth@colgate.edu

COLGATE UNIVERSITY

TO INCOMING STUDENTS: REPORT OF MEDICAL HISTORY (please print)

Last Name First Name Middle Initial Preferred First Name Cell Phone #

Address City State Country (If not U.S.A.) Zip + 4

Gender at Birth_____Current Gender_____Date of Birth (Month / Day / Year)_____/_____/_____Colgate Class Year_____Colgate Student ID # _____

Parent 1: Name Home Address Home Phone Cell Phone #

Business Address Business Phone

Parent 2: Name Home Address Home Phone Cell Phone #

Business Address Business Phone

FAMILY HISTORY: Adopted: Yes_____No_____

	Age	State of Health	Occupation	Age of Death	Cause of Death
Parent 1					
Parent 2					
Brothers					
Sisters					

Have any of your relatives ever had any of the following

	Yes	No	Relationship
Diabetes			
Kidney Disease			
Heart Disease			
High Blood Pressure			
Blood Clots			
Cancer			
Epilepsy/Other Neuro			

Please explain: _____

PERSONAL HISTORY: PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers in space below.

Have you had?	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Malaria			Recurrent Headaches			Stomach or Intestinal Trouble			Chronic Cough			ALLERGY TO: Penicillin/Amoxicillin		
Tuberculosis			Head Injury w/unconsciousness			Gallbladder Trouble			Shortness of Breath			Cephalosporins		
Mononucleosis			Fainting Spells			Skin Problem			Hay Fever			Sulfa		
Sinusitis			Palpitations (Heart)			Urine Infection			Asthma			Insect Bites		
Eye Trouble			High Blood Pressure			Kidney Problem			Tumor/Cancer (explain)			Foods (which)		
Ear Infections			Heart Murmur			Disease/Injury of Joints			SURGERY: Appendectomy			Other (explain)		
Throat Infections			Rheumatic Fever			Back Problems			Tonsillectomy			FEMALES ONLY: Severe Cramps		
Insomnia			Recent Weight Change			Seizures			Hernia Repair					
Frequent Anxiety			Hepatitis			Weakness/Paralysis			Other (explain)			Excessive Flow		
Frequent Depression														

REMARKS OR ADDITIONAL INFORMATION: _____

	No	Yes (Explain)
Has your physical activity been restricted during the past five years?		
Have you received treatment or counseling for mental health issues such as depression, anxiety, attention deficit or an eating disorder? If so, have arrangements been made for ongoing medication prescriptions?		
Have you been hospitalized other than already noted?		
Do you have any concerns about eating or weight?		
Do you currently receive allergy shots?		
Are you currently on any long-term medication?		

SPECIAL NEEDS

Do you believe that you have any special needs that the University should consider, in order to provide assistance with living and learning conditions?
□ Hearing □ Allergies □ Motor Deficits □ Dietary □ Vision □ Learning □ Speech □ Psychological Describe: □ Other
Describe:_____
Evelyn Lester, Director of Academic Support and Disability Services, is available to discuss your concerns. Phone: 315-228-7375 or e-mail elester@colgate.edu

I certify that, to the best of my knowledge, this information is correct. CONSENT FOR TREATMENT: The staff of the Colgate University Student Health Service has my permission for care and treatment; in person or via telehealth (virtual visits). This may additionally include care, treatment, **and exchange of medical information necessary for ongoing care** by any hospital, surgeon, physician, **psychiatrist/psychologist (including telepsychiatry)** or radiologist deemed necessary for appropriate medical, psychiatric, and/or surgical treatment. ***If under 18, parent/guardian must sign.***

Sign Here _____ *Student's Signature (parent/guardian if under 18) Date:*

_____ *Physician's Signature (Acknowledging Review) Date:* Sign Here

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TO THE EXAMINING HEALTH CARE PROVIDER: Please review the student's history and complete this form. Please comment on all the positive answers. THIS STUDENT HAS BEEN ACCEPTED. The information supplied will not affect the student's status: it will be used only as a background for providing health care. This information is strictly for the use of Health Services and will not be released without student consent. A PHYSICAL EXAM WITHIN THE LAST YEAR IS ACCEPTABLE.

Name:_____ DOB:_____was examined on this date: _____

Physical Exam was Normal: ☐ Y ☐ N Comments:_____

_____

Physical activity: ☐ Unlimited ☐ Limited (explain):_____

HT:_____ inches WT:_____lbs. BP:_____/_____ BMI:_____ VISION: Right Eye: 20/ Left Eye: 20/
WAS THIS WITH CORRECTIVE LENSES?____YES ___N0

ALLERGIES:

CURRENT MEDICATIONS:

RECENT LAB RESULTS:

PLEASE NOTE ANY HEALTH PROBLEMS, CHRONIC HEALTH CONDITIONS OR DISABILITIES:

Health care provider (M.D., D.O., P.A., N.P., R.N., school health professional, health official) verifying the above must sign below.
Name (please print): _____

Signature:_____Title:_____Date: _____

Address:_____Phone:_____ Fax: _____