PLEASE RETURN BY JULY 13th via postal mail or via fax at 315/228-6823

COLGATE UNIVERSITY STUDENT HEALTH SERVICES, 13 Oak Drive, Hamilton, NY 13346

315/228-7750 studenthealth@colgate.edu

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

Last Name First Name Middle Initial Preferred 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 | | | |

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 □ Other

Describe:_____

Lynn Waldman, Director of Academic Support and Disability Services, is available to discuss your concerns. Phone: 315/228-7375 or e-mail lwaldman@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 and treatment by any hospital, surgeon, physician, or radiologist deemed necessary for appropriate medical, psychiatric, and/or surgical treatment. *If under 18, parent/guardian must sign.*

*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.

NOTE: For the class entering in fall 2020, we understand it may be difficult to schedule a timely exam and this requirement can be waived but please complete the categories of allergies and current medications.

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 problem, chronic health condition or disability:

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): _____

Sign Here

Signature:_____Title:_____Date: _____

Address:_____Phone:_____ Fax: _____