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 Pronouns Cell Phone #

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

Gender at Birth_____Gender Identity _____Date of Birth (Month / Day / Year)_____/____/____Colgate Class Year_____Colgate Student ID # _____

Parent 1: Name Home Address Home Phone Cell Phone #

Parent 2: Name Home Address Home Phone Cell Phone #

FAMILY HISTORY: Adopted: Yes _____No____

	Age	State of Health	Occupation	Age of Death	Cause of Death
Parent 1					
Parent 2					
Siblings					

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: _____

Current Medications and Doses: _____

Will you Need Colgate to Prescribe your Medications?**YES** or **NO** If Yes, Which Medications: _____

Medication Allergies: If yes what happens. _____

	No	Yes (Explain) **Attach separate pg. if needed**
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, bipolar d/o, attention deficit, eating d/o, or other mental health diagnosis. If so, what arrangements have been made for ongoing care?		
Have you been hospitalized other than noted above in Personal History?		
Do you have any concerns about eating or weight?		
Do you currently receive allergy shots?		
Are you being treated for any chronic or long term condition? If so, what arrangements have been made for ongoing care?		

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 □ Vision □ Speech □ Dietary □ Allergies □ Learning □ Motor Disabilities □ Mental Health, ADHD or Autism Spectrum Support □ 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* *Date:*

Parent/Guardian Signature if Age < 18 *Date:* Sign Here