

**COLGATE UNIVERSITY HEALTH SERVICES, 13 Oak Drive, Hamilton, NY 13346 315/228-7750**

**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 \_\_\_

**Have any of your relatives ever had any of the following**

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

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

**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?		
Are you currently on any long-term medication?		
Do you currently get allergy shots?		

**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

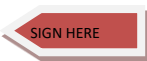
Describe: \_\_\_\_\_

Lynn Waldman, Director of Disability Services, is available to discuss your concerns. Phone 315/228-7375 or e-mail [lwaldman@colgate.edu](mailto: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. 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 \_\_\_\_\_**



**TO THE EXAMINING HEALTH CARE PROVIDER:** Please review the student's history and complete this form. Please comment on all 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 the Health Services and will not be released without student consent.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ was examined on this date: \_\_\_\_\_  
A PHYSICAL EXAM WITHIN THE LAST YEAR IS ACCEPTABLE

Physical Exam was Normal:  Y  N Comments: \_\_\_\_\_

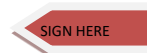
Physical activity:  Unlimited  Limited (explain): \_\_\_\_\_

HT: \_\_\_\_\_ inches WT: \_\_\_\_\_ lbs BP: \_\_\_\_/\_\_\_\_ BMI: \_\_\_\_\_ VISION: Right Eye: 20/ Left Eye: 20/  
WAS THIS WITH CORRECTIVE LENSES? \_\_\_ YES \_\_\_ NO

RECENT LAB RESULTS: ALLERGIES: CURRENT MEDICATIONS:

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): \_\_\_\_\_

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_