

SPRINGFIELD COLLEGE HEALTH CENTER

263 Alden Street / Springfield, Massachusetts 01109
(413) 748-3175 / (413) 748-3444 (fax)

This information is strictly for the use of Health Services and will not be released to anyone without your knowledge and consent.

HEALTH HISTORY

PLEASE NOTE: Full clearance for registration **WILL NOT** be granted until **ALL** health requirements have been met.

Name (last, first, middle):		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth:	Social Security Number:	Identification #:	
Address:			
Telephone Number:			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other			
Have you previously attended Springfield College? <input type="checkbox"/> No <input type="checkbox"/> Yes, when?			

EMERGENCY CONTACT

Name:	Relationship:
Address:	
Telephone Number: (Work)	(Home)

INSURANCE INFORMATION

Health Insurance Company:	Subscriber Name:
Address of Company:	Policy #
Telephone Number:	Group #

ALLERGIES

Medication Allergies:
Food Allergies:
Environmental Allergies:
Insect bite/sting Allergies:
Other Allergies:

CURRENT MEDICATIONS:

Name of Medication	Dosage and Dosing Schedule
_____	_____
_____	_____
_____	_____

FAMILY HEALTH STATUS

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brother(s)					
Sister(s)					

FAMILY HISTORY

Have any of your immediate relatives had any of the following?	YES	NO	RELATIONSHIP
Diabetes			
Tuberculosis			
Kidney Disease			
High Blood Pressure			
Heart Disease			
Sudden Death Under the Age of 50 from Nontraumatic Cause			
Stroke			
Marfan Syndrome			
Arthritis			
Asthma			
Seizure Disorder			
Cancer			
Stomach or Intestinal Disease			
Bleeding Disorder			
Alcoholism			
Psychiatric Disorder			
Other			

Student's Name: _____

HOSPITALIZATIONS AND SURGERIES:

Hospitalization or Surgery	Reason	Date	Complications
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PERSONAL HISTORY

Have you ever had:	YES	NO		YES	NO		YES	NO
1. Chicken Pox			21. Asthma			41. Musculoskeletal Injury		
2. Diabetes			22. Bronchitis or Pneumonia			42. Back Problem		
3. Seizure Disorder			23. Shortness of Breath			43. Scoliosis		
4. Head Injury or Concussion			24. Heart Murmur			44. Disease of the Joints		
5. Migraine Headache			25. Heart Problem			45. Dizziness or Fainting		
6. Tuberculosis			26. Chest Pain			46. Fainting With Exercise		
7. Anemia			27. Irregular Heart Rate			47. Heat-related Illness		
8. Sickle Cell Trait / Disease			28. Palpitations			48. Paralysis		
9. Bleeding Disorder			29. High Blood Pressure			49. Cancer		
10. Absence of Paired Organ			30. Elevated Cholesterol			50. Malaria		
11. Eye Problem			31. Stomach Problem or Ulcer			51. Insomnia		
12. Vision Loss			32. Intestinal Problem			52. Frequent Anxiety		
13. Ear Problem			33. Hepatitis			53. Clinical Depression		
14. Hearing Loss			34. Gallbladder Problem			54. Suicide Attempt		
15. Nose Problem			35. Hernia			55. Preoccupation with weight		
16. Sinusitis			36. Urinary Tract Infection			56. Preoccupation with food		
17. Throat Problem			37. Kidney Disease			57. Vomiting to control weight		
18. Infectious mononucleosis			38. Sexually Transmitted Disease			58. Laxative use to control weight		
19. Thyroid Disorder			39. DES Exposure			59. Anorexia / Bulimia		
20. Dental Problem			40. Skin Disorder			60. Any Other Problems Not Listed		

INCLUDE DATE AND DESCRIBE DETAILS FOR EACH "YES." USE SEPARATE PAGE FOR DETAILS IF NEEDED.

LIFESTYLE HABITS

	YES	NO	IF YES, SPECIFY AMOUNT
Caffeine (coffee, soda, tea, chocolate)			Cups per day
Cigarettes			Cigarettes per day
Alcohol			Drinks / Beers per week
Exercise			Hours per week
Do you wear seat belts?			(Circle one) Always Frequently Sometimes Never

STUDENT SIGNATURE

DATE