



CONFIDENTIAL INFORMATION – This information will be used by Student Health **ONLY**.

Please print or type legibly.

Please answer all questions. Return this form one month prior to registration for classes to:

Student Health
SUNY Upstate Medical University
750 East Adams Street
Syracuse, New York 13210

Program _____

Year of Graduation _____

Student's Statement

Date: _____

Name: _____ SSN #: _____
Last First Middle

Date of Birth: _____ Sex: Male Female Marital Status: Single Married Divorced Separated Widowed

Home Address: _____
City State Zip

Email: _____ Home Phone: _____ Cell Phone: _____

Country of Birth: _____ Years you have lived in the United States: _____

Ethnic Origin: Asian Black Caucasian Hispanic Other: _____

Emergency Contact: _____

Address and Phone Number: _____

Family Physician: _____

Address and Phone Number: _____

Family History

Relationship	State of Health				List any health problems
	Age	Good	Fair	Poor	
Father					
Mother					
Spouse					
Siblings					
Children					

Personal Health History

Please check **YES** or **NO** if you have **EVER** had or have any of the following. If **YES**, specify by number and explain on Page 2

- | | | |
|---|--|---|
| Yes No | Yes No | Yes No |
| 1. <input type="checkbox"/> <input type="checkbox"/> Chicken pox/Shingles | 11. <input type="checkbox"/> <input type="checkbox"/> Physical Disability | 21. <input type="checkbox"/> <input type="checkbox"/> Liver Disease |
| 2. <input type="checkbox"/> <input type="checkbox"/> Hepatitis | 12. <input type="checkbox"/> <input type="checkbox"/> Chest discomfort | 22. <input type="checkbox"/> <input type="checkbox"/> Skin problems |
| 3. <input type="checkbox"/> <input type="checkbox"/> Measles | 13. <input type="checkbox"/> <input type="checkbox"/> Heart Disease | 23. <input type="checkbox"/> <input type="checkbox"/> Kidney Disease/Stones |
| 4. <input type="checkbox"/> <input type="checkbox"/> Mononucleosis | 14. <input type="checkbox"/> <input type="checkbox"/> Heart murmur | 24. <input type="checkbox"/> <input type="checkbox"/> Urinary Tract Infection |
| 5. <input type="checkbox"/> <input type="checkbox"/> Mumps | 15. <input type="checkbox"/> <input type="checkbox"/> Palpatations | 25. <input type="checkbox"/> <input type="checkbox"/> Diabetes |
| 6. <input type="checkbox"/> <input type="checkbox"/> Polio | 16. <input type="checkbox"/> <input type="checkbox"/> Hypertension | 26. <input type="checkbox"/> <input type="checkbox"/> Thyroid problem |
| 7. <input type="checkbox"/> <input type="checkbox"/> Tuberculosis/Positive PPD | 17. <input type="checkbox"/> <input type="checkbox"/> Fainting spells | 27. <input type="checkbox"/> <input type="checkbox"/> Back trouble |
| 8. <input type="checkbox"/> <input type="checkbox"/> AIDS/HIV Infection | 18. <input type="checkbox"/> <input type="checkbox"/> Frequent indigestion | 28. <input type="checkbox"/> <input type="checkbox"/> Joint problem/Arthritis |
| 9. <input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Disease | 19. <input type="checkbox"/> <input type="checkbox"/> Peptic Ulcer Disease | 29. <input type="checkbox"/> <input type="checkbox"/> Fractures |
| 10. <input type="checkbox"/> <input type="checkbox"/> Bleeding Disorder | 20. <input type="checkbox"/> <input type="checkbox"/> Intestinal Disease | 30. <input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures |

Personal Health History *(continued)*

Please check **YES** or **NO** if you have **EVER** had or have any of the following.

- | Yes | No | | Yes | No | | Yes | No | | | | |
|-----|--------------------------|--------------------------|----------------------|-----|--------------------------|--------------------------|----------------------------|-----|--------------------------|--------------------------|------------------------------|
| 31. | <input type="checkbox"/> | <input type="checkbox"/> | Severe headaches | 36. | <input type="checkbox"/> | <input type="checkbox"/> | Anorexia/Bulimia | 41. | <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune Disease |
| 32. | <input type="checkbox"/> | <input type="checkbox"/> | Asthma/Lung Disease | 37. | <input type="checkbox"/> | <input type="checkbox"/> | Depression/excessive worry | 42. | <input type="checkbox"/> | <input type="checkbox"/> | Loss of limb |
| 33. | <input type="checkbox"/> | <input type="checkbox"/> | Recent weight change | 38. | <input type="checkbox"/> | <input type="checkbox"/> | Drug/Alcohol Dependency | 43. | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety or Panic Disorder |
| 34. | <input type="checkbox"/> | <input type="checkbox"/> | Tumor/Cancer | 39. | <input type="checkbox"/> | <input type="checkbox"/> | Learning Disability | 44. | <input type="checkbox"/> | <input type="checkbox"/> | Anemia/Blood disorder |
| 35. | <input type="checkbox"/> | <input type="checkbox"/> | Hearing difficulty | 40. | <input type="checkbox"/> | <input type="checkbox"/> | Vision impairment | 45. | <input type="checkbox"/> | <input type="checkbox"/> | Any other illness or disease |

If **YES**, specify by number and explain.

Please check **YES** or **NO** to each question. If **YES**, specify by number and provide details

- | Yes | No | | Yes | No | | Yes | No | | | | |
|-----|--------------------------|--------------------------|--------------------------|----|--------------------------|--------------------------|---|-----|--------------------------|--------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Do you take medications? | 7. | <input type="checkbox"/> | <input type="checkbox"/> | Emotional/Psychological problems (past or present)? | 10. | <input type="checkbox"/> | <input type="checkbox"/> | Past hospitalizations? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Medication Allergies? | 8. | <input type="checkbox"/> | <input type="checkbox"/> | Need to speak with the school psychologist? | 11. | <input type="checkbox"/> | <input type="checkbox"/> | Past surgeries? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Any other drug use? | 9. | <input type="checkbox"/> | <input type="checkbox"/> | Need to discuss health concerns? | 12. | <input type="checkbox"/> | <input type="checkbox"/> | Conditions requiring ongoing medical care? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Tobacco use? | | | | | | | | |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol use? | | | | | | | | |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Physical limitation? | | | | | | | | |

If **YES**, specify by number and explain.

I certify that the information documented on this form is true and complete to the best of my knowledge.

Student's Signature: _____ Date: _____

Health care provider's summary and elaboration of all pertinent data. Please comment on all positive answers.

Health Care Provider: _____ Date: _____