

**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

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

Your medical information will be viewed only by the Employee/Student Health medical staff and will only be released with a signed Release of Information provided by you.

I certify that the information documented on this form is accurate and complete.

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: \_\_\_\_\_