The College of Saint Rose

432 Western Avenue, Albany, NY 12203-1490 1.800.637.8556 www.strose.edu

Report of Medical History

Health Service

Phone (518) 454-5244; Fax 454-2007

Name: _____ Student ID Number: _____

Address: _____ Phone:_____ (cell) _____

City: _____ State: _____ Zip: _____ Date of Birth: _____ ☐ Male ☐ Female

FAMILY HISTORY

Father: ☐ Living ☐ Deceased Age at death and cause _____ Occupation: _____

Mother: ☐ Living ☐ Deceased Age at death and cause _____ Occupation: _____

HAS ANY BLOOD RELATIVE HAD?

Heart Disease	☐ Yes	☐ No	Marfan's Syndrome	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Seizure Disorder	☐ Yes	☐ No	Joint Disease	☐ Yes	☐ No
Sickle Cell Trait	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Stomach Problems	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No

HAVE YOU EVER HAD? Please answer all questions. Explain all "yes" answers below.

Heart Disease/Infection	☐ Yes	☐ No	Anemia Bleeding Disorder	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Cancer/Cyst	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Dizziness/Fainting	☐ Yes	☐ No	Recurrent Strep	☐ Yes	☐ No	Surgery	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Migraines	☐ Yes	☐ No	Recurrent Sinusitis	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Head Injury	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Back Problems	☐ Yes	☐ No
Asthma Lung Problems	☐ Yes	☐ No	Seizures	☐ Yes	☐ No	Stomach Problems	☐ Yes	☐ No	Joint Problems	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Eye/Vision Problems	☐ Yes	☐ No	Weight Gain/Loss	☐ Yes	☐ No	Skin Problems	☐ Yes	☐ No
Sickle Cell Trait	☐ Yes	☐ No	Ear Trouble	☐ Yes	☐ No	Eating Disorder	☐ Yes	☐ No	FEMALES ONLY		
Marfan's Syndrome	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Insomnia	☐ Yes	☐ No	Previous Gynecological		
ADD/ADHD	☐ Yes	☐ No	Urinary Infections	☐ Yes	☐ No	Anxiety/Depression	☐ Yes	☐ No	Exam	☐ Yes	☐ No

Explanation for "yes" answers above: _____

_____

_____

Allergies to medications, foods, or stinging insects:_____

List Medications regularly taken or required: _____

Emergency contact:

Name: _____ **Relationship:** _____ **Phone Number:** _____

CONSENT TO TREATMENT AND FINANCIAL RESPONSIBILITY

I hereby give permission for the above student to receive general, diagnostic and therapeutic medical treatment from the College of Saint Rose Health Service or such other health care provider as The College of Saint Rose shall determine necessary.

The undersigned student and parent/guardian accept financial responsibility for the expense of health care services, diagnostic and therapeutic medical treatment rendered to the above student by The College of Saint Rose Health Service or such other health care provider as The College of Saint Rose shall determine necessary. If you have health insurance, provide the name of company and policy number. Include the phone number from back of card.

_____

Company name Policy number Phone Number

Do you plan to participate on one of the intercollegiate athletic teams? ☐ YES ☐ NO

If YES, do you wish to authorize the release of the following Protected Health Information; Report of Medical History, Immunization Record and Health Evaluation to the Athletics Department at The College of Saint Rose? ☐ YES ☐ NO

- I understand that I waive any and all claims in connection with the communication and disclosure of such information. This authorization will expire one year from the date of signature. I understand I can revoke this authorization, in writing, at any time except to the extent that The College of Saint Rose Health Service has already taken action on the authorization.

Signature of Student _____ **Date** _____

Signature of Parent/Guardian _____ **Date** _____

(Must be signed by parent if student under age 18)