

Name: \_\_\_\_\_

Please indicate your student status:

\_\_\_ Freshman \_\_\_ Sophomore \_\_\_ Junior \_\_\_ Senior \_\_\_ First year @Concordia \_\_\_ Transfer Student \_\_\_ Returning Student

# CONCORDIA COLLEGE

NEW YORK

## Health Services

This is a confidential record. Information you provide will be used solely as an aid to providing health care while you are a student.

### Personal Information

Age \_\_\_\_\_  Male  Female Date of Birth \_\_\_\_\_  Single  Married  Widowed  Divorced

Name \_\_\_\_\_ Social Security# \_\_\_\_\_  
Last First Middle Maiden Name

Home Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Street City State Zip

Are you currently insured?  Yes  No Provider/Carrier/Company \_\_\_\_\_

Address of Provider \_\_\_\_\_ Telephone \_\_\_\_\_  
Street City State Zip

Name on Insurance Policy \_\_\_\_\_ Policy # \_\_\_\_\_

Insured date of birth \_\_\_\_\_ Name of Employer that provides insurance (if applicable) \_\_\_\_\_

*(Please attach a copy of the insurance card, front and back)*

Have you attended Concordia College before?  Yes  No If yes, From \_\_\_\_\_ To \_\_\_\_\_

Circle College Year 1 2 3 4 5 Have you attended another college?  Yes  No If yes, From \_\_\_\_\_ To \_\_\_\_\_

Person to be notified in emergency: Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_

### Personal History

Please answer all questions. Comment on all positive answers in space allowed (see next page).

Have you had:	Yes	No		Yes	No
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>			
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	Surgery:		
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	Hernia Repair	<input type="checkbox"/>	<input type="checkbox"/>
Nose/Throat Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Eye Trouble	<input type="checkbox"/>	<input type="checkbox"/>			
Recurrent Colds	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to:		
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Sulfonamides	<input type="checkbox"/>	<input type="checkbox"/>
			Serum	<input type="checkbox"/>	<input type="checkbox"/>
Joint Disease or Injury:			Foods (list below)	<input type="checkbox"/>	<input type="checkbox"/>
"Trick" Knee, Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>			
Diarrhea/Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Females Only		
Gallbladder/Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Rupture, Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Severe Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice (Liver Disease)	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Flow	<input type="checkbox"/>	<input type="checkbox"/>
Stomach/Intestine Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

Name \_\_\_\_\_

	Yes	No
Frequent Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Depression	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Head injury with Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Headache	<input type="checkbox"/>	<input type="checkbox"/>
Gum/Tooth Problems	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>
Epileptic Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Tumor, Cancer, Cyst	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness, Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Weakness/Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Pain/Pressure in Chest	<input type="checkbox"/>	<input type="checkbox"/>
High or Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Disease (STD)	<input type="checkbox"/>	<input type="checkbox"/>
Recent Weight Gain or Loss	<input type="checkbox"/>	<input type="checkbox"/>

- A. Has your physical activity been restricted during the past five years? Yes No (If yes, explain below.)
- B. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem?  
Yes No (If yes, give details below.)
- A. Have you had any illness or injury or been hospitalized other than already noted? Yes No (If yes, give details below.)
- B. Have you consulted or been treated by clinics, physicians, or other practitioners within the past five years?  
(other than routine checkups?) Yes No
- A. Do you smoke, dip, or chew tobacco? Yes No
- B. Do you take any medication at present? Yes No (List Below)

Comments:

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### Family History

Among your relatives is there any history or present illness from the following: If yes, what relative?

	Yes	No	Relative		Yes	No	Relative
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nervous difficulties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Any other disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease, high blood pressure, or stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____				

### Medical and Surgical Authorization

In case of illness and/or injury, authority and consent is given to Concordia College for examination and treatment of named student either at the Health Center, Concordia College, or by outside physicians and medical facilities as are available. Consent is further given for admission to a hospital for necessary medical or surgical treatments as ordered by a physician. It is agreed that all medical and/or hospital expenses incurred beyond those covered by any applicable student insurance policy will be paid directly and promptly by the undersigned student and parents or guardians and the College will not be held responsible.

Date \_\_\_\_\_ Student's Signature \_\_\_\_\_ Age \_\_\_\_\_

Date \_\_\_\_\_ Parent or Guardian's Signature \_\_\_\_\_  
(If under age 18 and unmarried, parent or guardian must also sign.)