STCC
Springfield Technical Community College

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(413) 781-7822 • www.stcc.edu

Health and Wellness Center · Building 19, Room 177 · Phone (413) 755-4230 · Fax (413) 755-6045

Student Health History Form

This form is available online at: www.stcc.edu/healthservices

Please return form to the Health and Wellness Center (students may fill in information on this form)

MAJOR: _____ **Student ID#** _____

NAME: _____
(last) (first) (middle)

ADDRESS: _____
(street) (city) (state) (zip code)

BIRTH DATE: _____ **TELEPHONE NUMBER:** _____

IN CASE OF EMERGENCY PLEASE CONTACT:
(name) (phone) (relation)

DO YOU HAVE ANY SPECIALIZED NEEDS IN THE EVENT OF AN EMERGENCY OR A BUILDING EVACUATION?

Check at left of each item. If "yes", explain as appropriate

YES	NO	HEALTH HISTORY
☐	☐	1. Hospitalization (date, reason)
☐	☐	2. Operation (date, type)
☐	☐	3. Serious accidents or illnesses
☐	☐	4. Prescription medications? Please list with reason for taking here:
☐	☐	5. Are you currently taking any non-prescription medications, vitamins or diet supplements? If so, please list here:
YES	**NO**	**ALLERGIES to MEDICATIONS and/or ENVIRONMENTAL FACTORS**
☐	☐	6. Allergies to medications? If so, please list:
☐	☐	7. Life threatening reaction to insect bites, food, etc.? If so, please specify:
☐	☐	8. Do you carry an epinephrine injection kit?

YES	NO	HAVE YOU EVER HAD:
☐	☐	9. Chicken Pox
☐	☐	10. Epilepsy (convulsions)
☐	☐	11. Head injury or concussion
☐	☐	12. Fainting or dizziness
☐	☐	13. High blood pressure
☐	☐	14. Any heart problems
☐	☐	15. Chronic or persistent respiratory infection
☐	☐	16. Asthma
☐	☐	17. Gastrointestinal disease
☐	☐	18. Gallbladder disease
☐	☐	19. Thyroid problem
☐	☐	20. Mononucleosis (diagnosed by a clinician)
☐	☐	21. Diabetes
☐	☐	22. Immune Deficiency Problems
☐	☐	23. Kidney disease
☐	☐	24. Cancer
☐	☐	25. Sexually transmitted disease
☐	☐	26. Gynecological problems
☐	☐	27. Are you pregnant or could you be pregnant?
YES	**NO**	**LIFESTYLE**
☐	☐	28. Do you drink alcohol? If so, drinks per week?
☐	☐	29. Current tobacco use: ☐ chew ☐ cigarette ☐ cigar ☐ pipe Quantity per day?
☐	☐	30. Currently Employed? Occupation:
☐	☐	31. Weekly Exercise: ☐Daily ☐3-5 times ☐1-3 times
☐	☐	32. Any recent unexpected weight loss or gain?

Other health concerns:

FAMILY HEALTH HISTORY

YES	NO	CONDITION	RELATIONSHIP	COMMENTS
☐	☐	High Blood Pressure		
☐	☐	Heart Disease		
☐	☐	Diabetes		
☐	☐	Cancer		
☐	☐	Mental/Emotional Illness		
☐	☐	Stomach or Intestinal Illness		
☐	☐	Kidney Disease		
☐	☐	Alcoholism		
☐	☐	Epilepsy/Convulsions		
☐	☐	Tuberculosis		
☐	☐	Stroke/Blood Clotting problems		
☐	☐	Death under age 50		

I ATTEST THAT THIS MEDICAL INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Student Signature) (Date)