



Department of Health Services • Building 20, Room 320 • 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 Health Services (students may fill in information on this form)

MAJOR: _____ Student ID# or SS#: _____
NAME: _____
(last) (first) (middle)
ADDRESS: _____
(street) (city) (state) (zip code)
BIRTH DATE: _____ HOME TELEPHONE: _____

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

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

Other health concerns:

FAMILY HEALTH HISTORY

YES	NO	CONDITION	RELATIONSHIP	COMMENTS
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure		
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease		
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes		
<input type="checkbox"/>	<input type="checkbox"/>	Cancer		
<input type="checkbox"/>	<input type="checkbox"/>	Mental/Emotional Illness		
<input type="checkbox"/>	<input type="checkbox"/>	Stomach or Intestinal Illness		
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease		
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism		
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Convulsions		
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis		
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/Blood Clotting problems		
<input type="checkbox"/>	<input type="checkbox"/>	Death under age 50		

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

(Student Signature)

(Date)