MEDAILLE COLLEGE MEDICAL HISTORY FORM

(To be completed by student)

Please print:

NAME _____
Last First MI

DOB _____ **SS** _____ **PHONE** _____ **SEX** ☐ **F** ☐ **M**

ADDRESS _____
Street City State Zip

EMERGENCY CONTACT _____ **HOME PHONE** _____
Name Relationship

ADDRESS _____ **BUSINESS PHONE** _____

PRIMARY PHYSICIAN _____ **PHONE** _____

ADDRESS _____
Street City State Zip

Please (**X**) all the medical problems you have or have had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Pressure Problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Collagen Disease
- ☐ Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse/Dependency
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Emotional Problems
- ☐ Fainting/Dizziness
- ☐ Frequent Ear, Nose, Throat Infections
- ☐ Gall Bladder Problems
- ☐ Hearing Loss
- ☐ Heart Disorder
- ☐ Hypoglycemia
- ☐ Joint/Back Trouble
- ☐ Kidney/Bladder Problems
- ☐ Migraine Headaches
- ☐ Musculoskeletal Disorders
- ☐ Neurological Disorders
- ☐ Polio
- ☐ Rashes
- ☐ Recurrent Nosebleeds
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Sexually Transmitted Diseases
- ☐ Sinusitis
- ☐ Stomach Disorders
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosiss
- ☐ Vision Problems
- ☐ Other

Please explain all checks: (Use the rear of form if necessary)

_____

_____

_____

Do you smoke? **YES/NO** _____ Packs/Day Do you use alcohol? **YES/NO** _____ /Week

FEMALES:

Irregular Periods _____ Severe Cramps _____ Excessive Flow _____

Are you allergic to any medication? Please list: _____

Are you allergic to any food/insect/environmental allergen? Please list: _____

Any surgeries or serious injures? Please list: _____

Are you on any medications? Please list: _____

AUTHORIZATION OF HEALTH SERVICES FOR STUDENTS UNDER 18 YEARS OF AGE

I am the parent or legal guardian of the above mentioned student, and I understand that situations may arise in which the student may need to be treated in the Student Health Center for a medical condition while at school and it may not be possible for the College to notify me before the care is rendered. I further understand that the College will make its best effort to notify me of this situation; however, if such notice is not possible, I authorize that care be rendered. Also, in the event of an emergency, I hereby authorize the Student Health Center to refer the student to a physician, health care institution, or other healthcare provider to perform any diagnostic, medical, or surgical treatment deemed necessary by the College Health Center.

_____ _____

Signature of Parent/Guardian **Date**