New Paltz
STATE UNIVERSITY OF NEW YORK

Student Health Service ▪ Division of Student Affairs
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HEALTH HISTORY

Student Name: ____ Date of Birth: ________________

Diseases in student (check box if history of this condition exists in student):

Chronic Medical Disorders

☐ Diabetes
☐ Seizure Disorder
☐ Anemia
☐ Sickle Cell Disease
☐ Heart Abnormality
☐ Kidney Disease
☐ Chronic Intestinal/Stomach Problem
☐ Arthritis
☐ Respiratory Allergies
☐ Hives
☐ Cancer
☐ Orthopedic Problems
☐ **Asthma**: **If yes, answer the following**:

Triggers: ☐ Weather changes ☐ Colds ☐ Exercise ☐ Allergies ☐ Other: ____

Medications for Asthma (e.g. Inhaler, nebulizer) ____

Infectious Disease

☐ Chicken Pox
☐ Frequent Respiratory Infections
☐ Mononucleosis
☐ Positive TB Skin Test
☐ Tuberculosis
☐ Malaria
☐ HIV/AIDS
☐ Hepatitis A, B, or C
☐ Pneumonia
☐ Sexually Transmitted Disease
☐ MRSA Skin Infection

Neurologic/Psychiatric Problems

☐ Head Injury/Concussion
☐ Emotional Disorder
☐ Depression
☐ Anxiety
☐ Attention Deficit Disorder
☐ Eating Disorder
☐ Hearing Deficit
☐ Visual Deficit
☐ Speech Deficits
☐ Fainting
☐ Alcohol/Drug Addiction
☐ Migraine Headaches

Medical problems other than listed above: ____

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Severe Injuries: ☐ Yes ☐ No Explain: ____

Operations: ☐ Yes ☐ No Explain: ____

Medications you are currently taking: ____

____

ALLERGIES to Medication: ____

ALLERGIES to Food: ____ ☐ mild ☐ moderate ☐ severe

ALLERGIES to Insects: ____ ☐ mild ☐ moderate ☐ severe

If your reaction is **moderate** or **severe**, what treatment do you take when you are exposed to the allergen? ______________________

____

Do you require an EpiPen? ☐ Yes ☐ No

Signature: ____ **Date:** _____________________