



CONFIDENTIAL HEALTH HISTORY

Please complete form, sign and return to Health Services by July 15th (Fall Semester), January 1st (Spring Semester), or May 15th (Summer Semester). All information is confidential and used only by the Health Services' professional staff in assuring the student's health and for addressing special needs during his/her college experience.

A \$5.00 fee per form will be assessed if any forms are returned late.

NAME: _____ M _____ F _____ Social Security # _____
Last First MI

HOME ADDRESS: _____ Home Phone No. _____
Number Street

_____ City _____ State _____ Zip _____ Cell Phone No. _____

DATE of BIRTH: _____ BIRTH PLACE: _____

MARITAL STATUS: Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

COLLEGE LAST ATTENDED: _____ YEAR: _____

CENTENARY ENTRANCE DATE: _____ STATUS: Resident _____ Commuter _____ Transfer _____

CLASS: Freshman _____ Sophomore _____ Junior _____ Senior _____ MAJOR _____

EMERGENCY INFORMATION

Parent/Guardian/Spouse/or next of kin to be notified in case of emergency:

NAME: _____ RELATIONSHIP: _____

HOME ADDRESS: _____ PHONE NO. : _____

EMPLOYER: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____ PHONE NO. _____

Self/Parent's MEDICAL INSURANCE CO.: _____ POLICY NO.: _____

Please list another person to be notified if unable to contact above name

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE NO.: _____

PERMISSION TO TREAT (print student's name): _____

This form **must** be signed by the individual, parent, or legal guardian so that care may be given. If under 18 years of age, parental consent is required and must be notarized so that medical care may be given.

"I the undersigned do hereby authorize the physical and mental health care professionals engaged by Centenary College to render care for treatment of physical or mental illness or injuries, and to make referral for diagnosis and treatment as may be deemed necessary for myself, son, or daughter."

DATE: _____ Signature: _____

SEAL (if minor): _____ Relationship: _____

HEALTH HISTORY

Allergy to medications? Yes ___ No ___ If yes, list medications _____

Other allergies (seasonal, food, etc.) _____

Have you ever had or been treated for:

<input type="checkbox"/> ADHD	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Frequent Headaches/Migraines	<input type="checkbox"/> Chlamydia
<input type="checkbox"/> Anxiety/Panic Disorder	<input type="checkbox"/> Gall Bladder Disease	<input type="checkbox"/> Gonorrhea
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Gastrointestinal/Celiac/Gerd	<input type="checkbox"/> Herpes
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Head Injury (Concussions)	<input type="checkbox"/> HIV
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Warts
<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Heart Cond./ Murmurs/Palpitations	<input type="checkbox"/> Other
<input type="checkbox"/> Body Piercing/Tattoos	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Bronchitis/Pneumonia	<input type="checkbox"/> Hepatitis/Jaundice	<input type="checkbox"/> Skin Disorder/Acne/Psoriasis
<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sleep Disorder/Apnea
<input type="checkbox"/> Chest Pain/Pressure	<input type="checkbox"/> Kidney/Bladder/Urine Infections	<input type="checkbox"/> Speech Disorder
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Stress
<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Substance Use/abuse
<input type="checkbox"/> Dental Problems	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Depression	<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Drug
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental Health Counseling	<input type="checkbox"/> Tobacco
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Orthopedic Problems	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Ear, Nose, Throat Problems	<input type="checkbox"/> Physical Activity Restrictions	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Emotional/Behavioral Problems	<input type="checkbox"/> Physical Handicap	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Epilepsy/Convulsion/Seizures	<input type="checkbox"/> Positive Tuberculosis Test	<input type="checkbox"/> Weight Problems
<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Reactions to insect bites	
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Rheumatic Fever	

Have you ever hadWomen Only (please circle)

Any problems with menstrual cycle	yes	no
Pregnancies	yes	no
Abortion/Miscarriage	yes	no
A recent pelvic exam/pap smear	yes	no
Take birth control pills	yes	no

Men Only (please circle)

Undescended testicles, testicular mass, lump	yes	no
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Do you take or regularly use:

Tobacco, Quantity _____ per day since age _____	yes ___ no ___
Alcohol, Quantity _____ per day since age _____	yes ___ no ___
Recreational Drugs	yes ___ no ___
Allergy Shots	yes ___ no ___
Vitamins/Minerals	yes ___ no ___
Contact Lenses	yes ___ no ___
Glasses	yes ___ no ___

Are there any other aspects of your health that might cause problems for you or require special arrangements? yes - no
Explain: _____List any medication you take regularly and explain why you need this medication. _____

I do hereby state the above information to be true to the best of my knowledge.

Signature: _____ Date: _____

For questions, please call Health Service (908) 852-1400 ext. 2206 or fax (908) 979-4290