

# CONFIDENTIAL HEALTH HISTORY

Please complete form, sign and return to Health Services by August 1<sup>st</sup> (Fall Semester), January 1<sup>st</sup> (Spring Semester), or June 1<sup>st</sup> (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 \_\_\_  
Last First MI Social Security #

HOME ADDRESS: \_\_\_\_\_  
Number Street Phone No.

\_\_\_\_\_ 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 \_\_\_\_\_

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## 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.: \_\_\_\_\_

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**PERMISSION TO TREAT** (print student's name): \_\_\_\_\_

The 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: \_\_\_\_\_

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**HEALTH HISTORY**

Allergy to medications? Yes \_\_\_ No \_\_\_ If yes, list medications \_\_\_\_\_

List any medication you take regularly and explain why you need this medication. \_\_\_\_\_

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 Disease (Colitis) | <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/Insomnia      |
| <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                    |   |

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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 |
|--|-----|----|

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 \_\_\_

Corrective Lenses yes \_\_\_ no \_\_\_

Glasses \_\_\_\_\_ Contacts \_\_\_\_\_

Are there any other aspects of your health that  
might cause problems for you or require special  
arrangements? yes \_\_\_ no \_\_\_

Explain: \_\_\_\_\_

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