MEDICAL HISTORY FORM

[ ] Russell Sage College
[ ] Sage Graduate School
Wellness Center, 65 1st Street
Troy, NY 12180
Phone: 518-244-2261
Fax: 518-244-2262

[ ] Sage College of Albany
[ ] School of Professional & Continuing Education
Wellness Center, 140 New Scotland Ave.
Albany, NY 12208
Phone: 518-292-1917
Fax: 518-292-1918

INFORMATION RECEIVED IS CONFIDENTIAL AND WILL *NOT* JEOPARDIZE YOUR ACCEPTANCE STATUS OR ACADEMIC STANDING

PLEASE PRINT

____
Last Name First Name Middle Date of Birth

( ) ( ) ____
Home Telephone No. Cell Phone # Student ID#

____
Home Address (Number and Street) City or Town State Zip Code

Gender __________ Class you are entering ___________

____
Name and Address of Next of Kin

AUTHORIZATION FOR TREATMENT: I DO HEREBY AUTHORIZE THE SAGE COLLEGES TO PROVIDE FIRST AID TREATMENT AND IN CASE OF EMERGENCY, I AUTHORIZE THE TRANSPORTATION INVOLVED AND THE TREATMENT NECESSARY BY A PRACTITIONER AND/OR AT A HOSPITAL AND I SHALL ASSUME ANY EXPENSES WHICH ARISE.

Signed ____
(Student)

Signed ____
(Parent or Guardian if student is under 18 years of age)

Family History				**Have any of your RELATIVES had any of the following?**			
Age	**State of Health**	**Age at death**	**Cause of death**		**Yes**	**No**	**Relationship**
Father				Tuberculosis			
Mother				Diabetes			
				Kidney Disease			
Brother(s)				Heart Disease			
				High Cholesterol			
				Stomach Disease			
				Asthma, Hay Fever			
				Epilepsy, Seizures			
Sister(s)				Cancer			
				High Blood Pressure			
				Blood Clots			
				Alcoholism			
				Sickle Cell			

Please list all medications currently being taken and dosage, frequency and condition for which it is being taken:

Medication	Dosage	Frequency	Condition

Personal History:
Please answer all questions

Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No
Anemia			Gallbladder Disease			Recurrent Headaches		
Anxiety Disorder			Head Injury with unconsciousness			Sexually Transmitted Disease		
Asthma			Heart Murmur			Significant Weight Changes (gain/loss)		
Blood Clots			Hepatitis (A, B, C)/Liver disease			Sinusitis		
Back Problems			Hernia			Skin Disorders		
Bronchitis			High Blood Pressure			Stomach Ulcers		
Cancer			Inflammatory Bowel Disease			Substance Abuse		
Chicken Pox (Year:)			Injury of Joints/Joint Disease			Throat Infections		
Depression			Irritable Bowl/"Nervous" Stomach			Thyroid Disorders		
Diabetes			Learning Disability			UTI or Kidney Infections		
Ear Problems/Hearing Loss			Lyme Disease			Vaginal Infections		
Eating Disorder			Menstrual Irregularities					
Epilepsy/Seizures/Convulsions			Ovarian Cysts					
Eye Problems			Pneumonia					

PROVIDE COMMENTS ON ALL "YES" ANSWERS:____________________________

____

____

____

PLEASE COMPLETE THE FOLLOWING:

Hospitalizations or Operations (give date & procedure) ________________________

____

Serious Injuries (including fractures, concussions, motor vehicle accidents, etc.) ____________________

____

Have you received or are you currently receiving counseling? Yes __________ No ____________

PLEASE NOTE THE WELLNESS CENTER PROVIDES FREE COUNSELING SERVICES TO OUR STUDENTS

List **ALL** allergies you have and your **REACTION** to them:

Medications: ____________________________________

Foods: ______________________________________

Bees/Insects: __________________________ Do you carry an EPI-PEN? Yes __________ No ___________

Environmental: ____________________________________

WELLNESS ASSESSMENT:

Alcohol use (type/amount/frequency): ______________________________

My diet routinely consists of: _________________________________

How often do you exercise? __________________________________

Tobacco use (type/amount): __________________________________

THE INFORMATION I HAVE PROVIDED IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

____________________________________ ________________
Student Signature Date

____________________________________ ________________
Parent Signature (If student is under 18 years of age) Date