

**Jamestown Community College  
Residential Student Health History  
\*Required\***

**In order to better assist your medical needs, please answer the following questions as accurately as possible. Please Note: This information is confidential, housed in the Health Center, and will not be released without your permission.**

Name \_\_\_\_\_ DOB \_\_\_\_\_ J# \_\_\_\_\_

**On-Campus Address** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Primary Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Emergency Contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_, ext. \_\_\_\_\_

**Personal Medical History**

Please answer yes or no below if you have had or are currently under treatment for any of the following:

- |                               |                            |                               |
|-------------------------------|----------------------------|-------------------------------|
| Alcoholism _____              | Emphysema _____            | Muscular Dystrophy _____      |
| Anemia _____                  | Emotional Problems _____   | Peptic Ulcer _____            |
| Anorexia _____                | Epilepsy _____             | Seizures _____                |
| Arthritis _____               | Gall Bladder Disease _____ | Severe Menstrual Cramps _____ |
| Asthma _____                  | GERD _____                 | STD _____                     |
| Back Disorder _____           | Hearing Impaired _____     | Skin Disorder _____           |
| Bronchitis, Chronic _____     | Heart Disease _____        | Thyroid Disease _____         |
| Bulimia _____                 | Hepatitis _____            | Tuberculosis _____            |
| Cancer _____                  | High Blood Pressure _____  | Visually Impaired _____       |
| Cerebral Palsy (CP) _____     | Hypoglycemia _____         | Other _____                   |
| Colitis/Irritable Bowel _____ | Kidney Disorder _____      |                               |
| Cystic Fibrosis _____         |                            |                               |
| Deafness _____                | Low Blood Pressure _____   |                               |
| Depression _____              | Migraine Headaches _____   |                               |
| Diabetes _____                | Multiple Sclerosis _____   |                               |

**Please explain any "YES" answers** \_\_\_\_\_

**Any serious injuries?** \_\_\_\_\_ **If yes, explain** \_\_\_\_\_

**Allergies:** (An allergy is a skin rash, hives, joint pain, swollen glands, stuffy nose and/or fever after exposure to something to which you're allergic).

**Do you have any allergies?** Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list all allergies: \_\_\_\_\_

**Medications:** Do you take any medicine, regularly? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, check those below.

- |                      |                     |                     |                           |                     |
|----------------------|---------------------|---------------------|---------------------------|---------------------|
| Allergy Shots _____  | Aspirin _____       | Diabetic Pill _____ | Heart Rhythm Med _____    | Pain Pill _____     |
| Antacid _____        | Asthma Meds _____   | Diuretic _____      | High Blood Pressure _____ | Sleeping Pill _____ |
| Antidepressant _____ | Birth Control _____ | Epilepsy Meds _____ | Insulin _____             |                     |
| Antihistamine _____  | Blood Thinner _____ | Headache Meds _____ | Laxative _____            |                     |

**Prescription Medicine** \_\_\_\_\_

**Disability:**

Any permanent Physical Disability? If Yes, what? \_\_\_\_\_

Do you use any devices? (i.e.: wheelchair, crutches, other)? \_\_\_\_\_