HEALTH centers

Jamestown Community College
Student Health History
Required

Date: _____

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 Centers, and will not be released without your permission. If you are involved in a medical emergency this form will be provided to EMS on arrival.*

Name _____ **DOB:** _____ **J#** _____ **Phone** _____
Preferred Name_____ **Sex** _____ **Gender Identity** _____ **Pronouns** _____
Address _____ **City**_____ **State** _____**Zip**_____
____ (Please check if you reside at JCC) **Dorm Building** ____North _____ South _____West

Emergency Contacts
Name _____ Phone _____Relationship _____
____ Check box if we are allowed to contact emergency contacts and share medical information.
Are you currently under a Doctor's care?___ Yes ___No If yes, please explain_____
Doctor Information _____
Do you use tobacco? ___Yes ___No If yes, please explain _____
Do you use controlled substances? ___Yes ___No If yes, please explain _____
Do you use Alcohol? ___Yes ___No If yes, please explain _____

Pregnant? ___Yes ___No **Taking oral contraceptives?** ___Yes ___No **Nursing?** ___Yes ___No

Allergies _____
_____ Please check box if you are prescribed an EpiPen

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

	YES	NO		YES	NO		YES	NO
Alcoholism			Colitis			Hepatitis		
Anemia			Diabetes Type 1			Hypertension		
AIDS/HIV			Diabetes Type 2			Hypotension		
Anaphylaxis			Depression			Multiple Sclerosis		
Asthma			Deafness			Muscular Dystrophy		
Arthritis			Drug addiction			Skin Disorder		
Anorexia			Dizziness			Thyroid Disease		
Bulimia			Epilepsy			Tuberculosis		
Back disorder			Emphysema			Ulcers		
Bronchitis			Fainting spells			**Other:**		
Cancer			GERD					
Chemotherapy			Heart Disease					
Chest pains								

Medications: Do you take any medicine regularly? ___ Yes ___ No If yes, please list below:

_____

_____

I hereby certify that, to the best of my knowledge, the information provided is true and accurate. I understand that the information provided will be used to assist in my care plan and further medical care when necessary. I understand that it is my responsibility to update medical information when necessary.

Signature (Guardian, if under 18):_____ Date:_____

JCC JAMESTOWN COMMUNITY COLLEGE SUNY