

**UNION COLLEGE HEALTH SERVICES  
MEDICAL HISTORY AND PHYSICAL EXAMINATION FORM**

THIS FORM MUST BE RETURNED  
IN THE ENCLOSED ENVELOPE.

**RETURN TO:  
Union College  
Health Services  
Silliman Hall  
807 Union Street  
Schenectady, NY 12308  
Phone 518-388-6120  
Fax 518-388-6147**

Name \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip code \_\_\_\_\_  
Student Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Expected Date of Graduation \_\_\_\_\_

Check appropriate box.  Freshman  Transfer  Foreign Exchange--Country of Origin \_\_\_\_\_

**Emergency Data**

Parent/Guardian \_\_\_\_\_ Address(if different) \_\_\_\_\_

Home Telephone \_\_\_\_\_ Business Telephone \_\_\_\_\_

If unable to reach please contact:

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

<b>FAMILY HISTORY</b>	<b>AGE</b>	<b>STATE OF HEALTH</b>	<b>OCCUPATION</b>	<b>AGE AT DEATH</b>	<b>CAUSE OF DEATH</b>
FATHER					
MOTHER					
BROTHERS					
SISTERS					

<b>HAVE YOUR RELATIVES HAD:</b>	<b>Y</b>	<b>N</b>	<b>RELATION</b>
TUBERCULOSIS			
DIABETES			
KIDNEY DISEASE			
HEART DISEASE			
ARTHRITIS			
GASTRO INTEST.			
ASTHMA, HAY FEVER			
EPILEPSY			
CANCER			
MENTAL ILLNESS			

**PERSONAL HISTORY: PLEASE ANSWER ALL QUESTIONS**

<b>HAVE YOU HAD?</b>	<b>YES</b>	<b>NO</b>	<b>Explanation:</b>
1. Chicken Pox			
2. Ear Problems/Hearing Loss			
3. Eye Problems			
4. Sinusitis			
5. Recurrent Headaches / Migraines			
6. Head Injury with unconsciousness			
7. Recurrent Strep Throat			
8. Thyroid Disorder			
9. Pneumonia			

YES NO Explanation:

	YES	NO	Explanation:
10. Heart Murmur			
11. Mitral Valve Prolapse			
12. High Blood Pressure			
13. Stomach Ulcers			
14. Hepatitis (A, B, C)			
15. Skin disease or condition			
16. Asthma			
17. Inflammatory Bowel Disease			
18. Kidney/Bladder Infection			
19. Sexually Transmitted Disease			
20. Menstrual Disorder			
21. Seizure Disorder			
22. Cancer			
23. Sickle Cell/Sickle Cell Trait			
24. Anemia			
25. Back Problems			
26. Mononucleosis			
27. Diabetes			
28. Tuberculosis			
29. Ulcers			
30. Other			

**PLEASE COMPLETE THE FOLLOWING:**

Hospitalizations or Operations (give dates & procedures) \_\_\_\_\_

\_\_\_\_\_

Serious Injuries (including fractures, motor vehicle accidents, etc.) \_\_\_\_\_

\_\_\_\_\_

Counseling for Emotional Disorders/Psychiatric Treatment/Drug or Alcohol Rehabilitation \_\_\_\_\_

\_\_\_\_\_

Allergies (medications, food, environment; i.e., insects, chemicals, animals) \_\_\_\_\_

\_\_\_\_\_

Do you receive allergy shots? YES  NO  Will you be receiving shots while at school? YES  NO

List any medications currently taking and reason: \_\_\_\_\_

\_\_\_\_\_

Tobacco use type/amount: \_\_\_\_\_ Alcohol use/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

PHYSICIAN TO COMPLETE

THIS FORM MUST BE RETURNED TO: UNION COLLEGE HEALTH SERVICES, SILLIMAN HALL, 807 UNION ST., SCHENECTADY, NY 12308.

Student Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of examination \_\_\_\_\_

PHYSICAL EXAMINATION

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure S \_\_\_\_\_ D \_\_\_\_\_

Vision: Right 20/\_\_\_\_\_ Left 20/\_\_\_\_\_ Corrected Right 20/\_\_\_\_\_ Left 20/\_\_\_\_\_ Glasses \_\_\_\_\_ Contact Lenses \_\_\_\_\_

Table with 4 columns: NORMAL, ABNORMAL, PLEASE CHECK EACH ITEM:, PLACE ITEM NUMBER BEFORE EACH COMMENT. Rows list 17 items for physical examination.

List special dietary requirements: \_\_\_\_\_

Allergies (medications, food, environment, etc.) \_\_\_\_\_

Are any medications regularly taken or required? YES [ ] NO [ ] If yes, the following medicine and dosage required \_\_\_\_\_

Has patient ever been treated for psychological problems, substance abuse, or eating disorders? YES [ ] NO [ ]

If yes, describe \_\_\_\_\_

Do you have any recommendations regarding the care of this student or other conditions needing follow-up at school?

[ ] YES [ ] NO If yes, describe \_\_\_\_\_

Is this student medically able to participate in CONTACT sports? YES [ ] NO [ ] If no, describe \_\_\_\_\_

Is this student medically able to participate in NON-CONTACT sports? YES [ ] NO [ ] If no, please describe \_\_\_\_\_

HEALTH CARE PROVIDER'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE# \_\_\_\_\_ FAX# \_\_\_\_\_