

SYRACUSE UNIVERSITY HEALTH FORM

Please print in black or blue ink

You are responsible for returning these forms in their entirety to Health Services. **We suggest that you copy these forms for your records.**

PART 1: TO BE FILLED OUT BY THE STUDENT

Full Legal Name: _____ Date: _____

Last (or family) First Middle (or maiden)

Date of Birth: _____ Age: _____ Sex: _____ Social Security Number: _____

Home Address: _____

& Street City State Zip Code

Telephone: _____ / _____ Class at SU _____ Undergrad Grad

Country Area Code (Circle One)

Marital Status: _____ Birthplace: _____ Religion (optional): _____

Personal Physician: _____ Address: _____ Telephone: _____ / _____

Medical Insurance: _____ Policy Number: _____

Address: _____ Telephone: _____ / _____ Subscriber: _____

Have you ever been a student at SU before? _____ If so, indicate when you graduated or separated:

Date of Graduation/Separation: _____ Name (if changed): _____

Next of kin or person to be notified in case of emergency:

Name: _____ Relationship: _____

Address: _____ Telephone: _____ / _____

TO ALL STUDENTS, PARENTS, PHYSICIANS:

Please be candid on this form. This person will presumably be a resident of Syracuse for the next few years and anything less than full disclosure could be mutually disadvantageous. This is a highly confidential document for sole use by the professional staff at Syracuse University Health Services. **NO INFORMATION ON IT MAY BE RELEASED TO ANYONE WITHOUT THE STUDENT'S WRITTEN CONSENT.** If there are any questions, please contact the Director of Health Services.

MEDICAL CARE AUTHORIZATION:

"I, the undersigned, hereby specifically authorize Syracuse University Health Services and/or any authorized member of its staff, or duly affiliated consultant, to provide care in the Syracuse University Health Service and for emergency treatment, including mental health."

SIGNATURE OF STUDENT: If under 18 years of age signature of both parent/guardian and student is required.

STUDENT: _____ DATE: _____

PARENT/GUARDIAN: _____ DATE: _____

NOTE: WITHOUT THIS SIGNED AUTHORIZATION, HEALTH SERVICES CANNOT TREAT THIS STUDENT

If you have any physical and/or emotional disabilities that may require consideration in terms of mobility, class access, hearing or visual assistance, room assignment, etc., please describe them on page 3. This will in no way affect your current acceptance to Syracuse University but will allow us to plan in advance to assist you when you arrive on campus.

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

Note: If you answer "YES" to any of the following please explain in the space provided on page 3.

	YES
ALLERGIES TO:	
Medication	
Food	
Environment	
CUTANEOUS (SKIN)	
Acne	
Eczema/allergic skin disease	
Psoriasis	
Ophthalmic problems (include glasses/contacts)	
RESPIRATORY	
Asthma	
Bronchitis	
Hay Fever	
Pneumonia	
Ruptured/perforated eardrum	
CARDIOVASCULAR (HEART)	
Heart murmurs (specify if possible)	
Heart pounding/skipping	
High/low blood pressure	
Phlebitis	
Rheumatic Fever	
Have you ever had your cholesterol checked? Result (if known)	
GASTROINTESTINAL	
Abdominal pain (severe/recurrent)	
Blood in the stool	
Diarrhea (chronic/recurrent)	
Hepatitis	
Hernia	
Parasitic infection	
Ulcer	
Ulcerative colitis/Crohn's Disease	
GENITOURINARY	
Amenorrhea (no periods)	
Blood/protein in urine	
Cystitis (bladder infection)	
Dysmenorrhea (painful periods)	
HPV (genital warts)	
Nephritis or other kidney disease	
Pregnancy	
In her pregnancy which resulted in your birth, did your mother receive any DES (diethylstilbestrol)?	
MUSCULOSKELETAL	
Back problems	
Fractures/joint disability	
Severe sprains, ligament injury	
METABOLIC/ENDOCRINE/NUTRITION	
Diabetes	
Thyroid disorder (specify)	

Eating disorder (anorexia, bulimia)		YES
HEMATOLOGIC		
Anemia		
Mononucleosis		
NEUROLOGIC/PSYCHIATRIC		
Dizzy or fainting spells		
Frequent or severe headaches		
Seizures		
Severe head injury		
Depression		
Psychosis		
Psychotherapy		
INFECTIOUS DISEASES		
Tuberculosis		
STD (sexually transmitted disease)		
Rubella (German measles)		
Whooping cough (pertussis)		
PAST MEDICAL HISTORY		
Have you ever been hospitalized or had any operations?		
Do you have any major medical problems?		
Do you take any medications? (include vitamins and birth control pills)		
Do you receive allergy shots?		
Is there a family history of any major medical problems (allergies, cancer, diabetes, heart disease, high blood pressure, mental illness, tuberculosis, or hereditary disease)?		
Is there any other information you would like us to know about your health?		

FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH
Father				
Mother				
Brothers				
Sisters				
Children				

PLEASE USE THIS SPACE TO ELABORATE THE COURSE AND OUTCOME OF ALL SITUATIONS IDENTIFIED IN THE "YES" COLUMN ON PAGE 2.

All of the information on this form is accurate to the best of my knowledge.

STUDENT SIGNATURE: _____ DATE: _____

PART 2: MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PRACTITIONER.

To the practitioner: a physical examination and/or assessment of the physical status of this student from previous examinations and knowledge of the individual is needed for registration at Syracuse University. Please fill out completely.

Ht. _____ Wt. _____ BP _____ Visual Acuity Uncorrected Corrected
 L 20/ R 20/ L 20/ R 20/

	Normal	Abnormal	Please comment on all abnormal
H.E.E.N.T.			
Lungs and Chest			
Heart (including murmurs)			
Abdomen			
Extremities/Feet			
Musculoskeletal			
Skin			
Lymph nodes			
Neurologic			

HEALTH CARE PRACTITIONER'S SIGNATURE: _____ DATE: _____

