Cayuga HEALTH | ITHACA COLLEGE

Health History Form

What is your preferred name? _____

What is your sex assigned at birth? ☐ Male ☐ Female

What is your gender identity? _____

What are your preferred pronouns? _____

Please be aware that you can update the information you provided above in the "Profile" tab of the portal. Please keep your local address and preferences current, so that we can better serve you throughout your time as a student at Ithaca College.

Please select all that apply to your medical history:

Blood Disorders:
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Blood clots/Phlebitis
- ☐ Sickle Cell Trait or Disease

Bone and Joint Problems:
- ☐ Arthritis
- ☐ Back pain, chronic
- ☐ Repetitive Stress Injury
- ☐ Scoliosis

Cancer:
- ☐ Breast Cancer
- ☐ Lymphoma
- ☐ Melanoma
- ☐ Testicular Cancer

Disability:
- ☐ Hearing Impaired
- ☐ Learning Disability
- ☐ Mobility/Wheelchair
- ☐ Vision impaired

Neurological (Brain):
- ☐ Attention Deficit
- ☐ Concussion
- ☐ Migraine Headaches
- ☐ Seizure

Gastrointestinal/Stomach:
- ☐ Acid reflux
- ☐ Inflammatory Bowel Disease
- ☐ Irritable Bowel Syndrome
- ☐ Ulcer (Duodenal or Peptic)

Heart/Cardiovascular:
- ☐ Heart Murmur
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke

Infections:
- ☐ Chicken Pox
- ☐ Hepatitis B or C
- ☐ HIV Infection
- ☐ Mononucleosis
- ☐ Sexually Transmitted Infection
- ☐ Tuberculosis or Positive PPD

Mental Health:
- ☐ Alcoholism/Drug abuse
- ☐ Anxiety Disorder
- ☐ Attention Deficit Disorder
- ☐ Bipolar Disorder (Manic/Depression)
- ☐ Depression
- ☐ Eating Disorder

Endocrine:
- ☐ Diabetes
- ☐ Thyroid Disorder

Respiratory/Breathing:
- ☐ Asthma
- ☐ Hay Fever/Allergies

Skin Problems:
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis

Urinary:
- ☐ Bladder Infections (Cystitis)
- ☐ Kidney Infection
- ☐ Kidney Stones

Women's Health:
- ☐ Abnormal Pap Smear
- ☐ Endometriosis
- ☐ Menstrual Problems
- ☐ Pelvic Inflammatory Disease
- ☐ Polycystic Ovary Syndrome
- ☐ Pregnancy

Miscellaneous Health Problems:
- ☐ Lupus
- ☐ Smoker, Current
- ☐ Smoker, Past
- ☐ Weight problems

Do you have any other health problems not identified above? If so, please list and explain:

_____

PERSONAL MEDICAL HISTORY ADDITIONAL COMMENTS

If you checked any of the conditions listed above, please explain:

_____

_____

_____

_____

**Student's Cell Phone Number: _____

☐ **I verify that I have reviewed the list of personal health history conditions above and have marked any that apply to me.

FAMILY MEDICAL HISTORY:

Please select all that apply to your family medical history:

Blood Disorders:
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Blood clots/Phlebitis
- ☐ Sickle Cell Trait or Disease
- ☐ Thalassemia

Respiratory/Breathing:
- ☐ Asthma
- ☐ Hay Fever/Allergies

Infections:
- ☐ Hepatitis B or C
- ☐ Tuberculosis or Positive PPD

Cancer:
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Melanoma
- ☐ Ovarian Cancer

Gastrointestinal/Stomach:
- ☐ Acid reflux
- ☐ Inflammatory Bowel Disease
- ☐ Irritable Bowel Syndrome
- ☐ Ulcer (Duodenal or Peptic)

Mental Health:
- ☐ Alcoholism/Drug abuse
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder (Manic/Depression)
- ☐ Depression
- ☐ Suicide

Neurological (Brain):
- ☐ Alzheimer's Disease
- ☐ Migraine Headaches
- ☐ Seizure

Heart/Cardiovascular:
- ☐ Heart disease/Heart Attack
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke

Endocrine:
- ☐ Diabetes
- ☐ Thyroid Disorder

Miscellaneous Health Problems:
- ☐ Other

Parent Name: _____
Occupation: _____
Telephone #: _____

Parent Name: _____
Occupation: _____
Telephone #: _____

How many siblings do you have? _____

☐ **I verify that I have reviewed the list of medical conditions above and have marked any that apply to my Family Medical history.

Hospitalizations/Surgeries/Other Medical Procedures

Please list any surgical procedures or hospitalizations you have had:

#	Description	Approx Date

Surgical History/Hospitalization/Other Procedures Additional Comments:

_____
_____
_____
_____

☐ **I verify that I have reviewed and listed any applicable hospitalizations, surgeries, or procedures above.

Current Medications

Please list any current (frequent or regular) medications below:

#	Name of Medication	Dosage of Medication

☐ I am not currently taking any medications.

Please list any vitamins or supplements below:

_____
_____
_____
_____

☐ **I verify that I have reviewed the above section, and have listed any medications that I am currently taking.

Allergies to Drugs or Other Severe Adverse Reactions

Please list any allergies or adverse reactions to medications below

#	Name of Substance	Type of Reaction	Approx Date of Onset

☐ I do not have any known drug allergies.

Please list any substances or materials to which you have an allergy or history of severe reactions:

_____
_____
_____
_____

☐ **I verify that I have reviewed the above section and have listed any allergies or sensitivities that I have to medications or other substances.