



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Student ID: \_\_\_\_\_

### MEDICAL HISTORY

**NOTIFICATION OF SPECIAL MEDICAL CONSIDERATIONS:** *in an effort to be productively responsive to students needs, the University Health Services would like to be alerted to any special medical conditions or concerns that may require special attention or care. Please attach or forward any medical records that may be needed in order to provide appropriate care to this student while they are at college. Also, since we cannot automatically assume responsibility for a student's care without their willing participation, please instruct them to contact the Student Health Services office to make an appointment when needed.*

**Current Medical History/Condition(s):** \_\_\_\_\_

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**Allergies/Allergens:** \_\_\_\_\_

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**Medications Taken Regularly: (name/dosage)** \_\_\_\_\_

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**Medical History:** Check if you have ever had any of the following. Comment on all checked conditions in the space below:

YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/> Acne (under treatment)	<input type="checkbox"/>	<input type="checkbox"/> Alcohol/drug use, problem or treatment
<input type="checkbox"/>	<input type="checkbox"/> Anxiety	<input type="checkbox"/>	<input type="checkbox"/> Anemia
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Asthma
<input type="checkbox"/>	<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/> Bleeding trait
<input type="checkbox"/>	<input type="checkbox"/> Blood disorder	<input type="checkbox"/>	<input type="checkbox"/> Breast disease
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> Cerebral palsy
<input type="checkbox"/>	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/> Chronic Bronchitis/emphysema
<input type="checkbox"/>	<input type="checkbox"/> Crohn's Disease/IBS	<input type="checkbox"/>	<input type="checkbox"/> Chronic kidney condition
<input type="checkbox"/>	<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/> Diabetes (type I or II)
<input type="checkbox"/>	<input type="checkbox"/> Digestive trouble	<input type="checkbox"/>	<input type="checkbox"/> Eating disorder (anorexia/bulimia)
<input type="checkbox"/>	<input type="checkbox"/> Emotional/mental illness	<input type="checkbox"/>	<input type="checkbox"/> Fracture/sprains
<input type="checkbox"/>	<input type="checkbox"/> Hay fever	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis
<input type="checkbox"/>	<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/> Insomnia/sleep problems
<input type="checkbox"/>	<input type="checkbox"/> Kidney stones	<input type="checkbox"/>	<input type="checkbox"/> Menstrual problems
<input type="checkbox"/>	<input type="checkbox"/> Migraine/recurrent headaches	<input type="checkbox"/>	<input type="checkbox"/> Pelvic infection
<input type="checkbox"/>	<input type="checkbox"/> Peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/> Phlebitis
<input type="checkbox"/>	<input type="checkbox"/> Pregnancy	<input type="checkbox"/>	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/> Seizure disorder (epilepsy)	<input type="checkbox"/>	<input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/>	<input type="checkbox"/> Skin disorder	<input type="checkbox"/>	<input type="checkbox"/> Systemic lupus
<input type="checkbox"/>	<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/> Tobacco use
<input type="checkbox"/>	<input type="checkbox"/> Urinary infection	<input type="checkbox"/>	<input type="checkbox"/> Other: _____

**If you answered yes to any of the above, please explain:** \_\_\_\_\_

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### Insurance Information

(Only for laboratory or x-ray services/referrals—Student Health Services **does not** utilize insurance. Students pay for medications and/or laboratory services done on site. Fees are payable at the time of service by cash, check, charge or the University Hawk Flex card)

Name of Insurance: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Is prior authorization required for referrals? \_\_\_\_\_ Laboratory Services? \_\_\_\_\_

Please provide any other additional information you feel would be needed in case of an emergency or health related situation: \_\_\_\_\_

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Emergency Contact Information:

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*Please make sure all sides are filled out completely and designated forms are signed by your medical provider. All forms must be at the Student Health office prior to moving onto or attending classes to comply with The State of Connecticut's Department of Public Health's mandate.*

*The University does not permanently store these records. Please keep a copy for your permanent records. To reduce unnecessary paper copies, please do not mail and fax—only send one completed copy. Thank you for your prompt attention*