

**HUSSON COLLEGE  
STUDENT HEALTH SERVICE  
1 College Circle  
Bangor, ME 04401**

Full Name \_\_\_\_\_ Sex M \_\_\_\_\_ F \_\_\_\_\_  
Last First Middle  
 Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Local Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Name of Parent or Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Their Home Address \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Their Business Address \_\_\_\_\_ Business Phone: \_\_\_\_\_  
 Person to Contact in Emergency \_\_\_\_\_ Phone: \_\_\_\_\_

**Health & Accident Insurance**

Company: \_\_\_\_\_ Policy No. \_\_\_\_\_  
 Address: \_\_\_\_\_ Group No. \_\_\_\_\_  
 Name of Policy Holder: \_\_\_\_\_

**Family History**

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

**Has any blood relative (parent, brother, sister, other) had:**

Check Each Item	Yes	No	Relationship
Diabetes			
Kidney Disease			
Heart Disease			
High Blood Pressure			
Tuberculosis			
Cancer			
Alcoholism			
Substance Abuse			
Mental Illness			
Other			

**PLEASE ANSWER ALL QUESTIONS**

**Do You Have a Present or Past History Of:**  
(check each item)

Past	Present	No Problem		Past	Present	No Problem	
			Eye Problems				Blood Clotting Problems
			Ear, Nose or Sinus Problems				Congenital or Birth Defects
			Throat/Tonsillar Infections				Cancer or Malignancy
			Infectious Mononucleosis				Non-Malignant Tumor
			Asthma				Thyroid Disorder
			AIDS				Diabetes
			Tuberculosis				Epilepsy or Seizures
			Other Lung Infections				Headaches
			Rheumatic Fever				Depression
			Heart Murrur				Anxiety or Tendency to Worry
			Chest Pain				Skin Problems
			Rapid Heart Beat				Measles (Red or Rubeola)
			High Blood Pressure				Measles (German or Rubella)
			Ulcer(Stomach/Duodenal)				Mumps
			Recurrent Diarrhea				Chickenpox
			Colitis/Enteritis				Gynecological Problems
			Hepatitis; type, if known				Herpes/Other Genital Infection
			Bladder or Kidney Infection				Back Problems
			Kidney Stone				Bone or Joint Problems
			Anemia or Blood Disorder				Sports Related Injuries

If any of the above questions are answered yes, please explain \_\_\_\_\_

**Medical History**

- Do you have any medical problems? (such as asthma, diabetes, high blood pressure, etc.) Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain \_\_\_\_\_
- Have you consulted a physician or been hospitalized within the past five years? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain. \_\_\_\_\_
- Please list any surgery, major illnesses, or significant injuries which you have had including dates \_\_\_\_\_
- Are you taking any medications regularly at the present time, or have you taken any in the past, (including oral contraceptives, antidepressants, allergy injections, etc.)? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list \_\_\_\_\_
- Are you allergic to any medications or other substances? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, list and describe reactions: \_\_\_\_\_
- What is your present weight? Your present height? \_\_\_\_\_ Have you had significant weight loss or gain recently? Yes \_\_\_\_\_ No \_\_\_\_\_ Are you satisfied with your present weight? Yes \_\_\_\_\_ No \_\_\_\_\_ Please explain \_\_\_\_\_
- Do you eat a balanced diet daily? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, how much, and for how many years? \_\_\_\_\_  
Do you drink alcoholic beverages? Yes \_\_\_\_\_ No \_\_\_\_\_  
If so, type and number of drinks per week \_\_\_\_\_  
Are you concerned about your utilization of alcohol or drugs? Yes \_\_\_\_\_ No \_\_\_\_\_  
Have you been treated for alcohol or drug abuse? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, when \_\_\_\_\_
- Do you have any restrictions on your physical activities? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, please explain \_\_\_\_\_
- Is there any other information which would be helpful to the Student Health Service in providing you with medical care? \_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS**

Use an extra sheet of paper for explanation,  
if necessary.

**Per mission for Health Care and Emergency Treatment**

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Signature of Parent or Guardian if Student is Under 18

Date: \_\_\_\_\_