



Plymouth State UNIVERSITY

Health Questionnaire

NAME _____ DOB: __/__/____

(Please Print Last, First, M.I.)

HOME ADDRESS: Street _____ City _____ State _____ Zip _____

LOCAL ADDRESS: Street _____ City _____ State _____ Zip _____

PSU Suite Box: _____ Local Telephone: _____ Cellphone Number _____

Email Address _____

INSURANCE INFORMATION:

Does your student have health insurance? YES NO Name of Health Insurance Co. _____

Policy Number _____ Subscriber's Name _____

If you checked YES, we encourage you to verify that your student will be covered while attending PSU in the event services beyond those provided by the Health Service are necessary.

If you checked NO and are interested in individual policies available, please check the Health Services website at: <http://www.plymouth.edu/health/>

EMERGENCY NOTIFICATION

Name: _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____ Cell Phone _____

Email Address _____

PERSONAL HEALTH HISTORY

(The following questions are to help us understand your health needs and all information is kept confidential!)

Have you ever had or do you now have any of the following health problems?

	NO	YES		NO	YES
Allergies(Hay Fever or Astma)	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>
Smoke Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	Any Activity Restrictions		
Trouble Breathing	<input type="checkbox"/>	<input type="checkbox"/>	(in the past 5 years)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease or Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Psychological or Emotional		
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain with Exercise	<input type="checkbox"/>	<input type="checkbox"/>	Cancer or Impaired Immunity	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or Fainting with Exercise	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Neck or Back Injuries	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer or Stomach Irritation	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Backaches	<input type="checkbox"/>	<input type="checkbox"/>
Constipation or Chronic Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Knee Injury	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Ankle Injuries	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bone(s)	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Function or Absence of one			Joint Problems (Arthritis)	<input type="checkbox"/>	<input type="checkbox"/>
Testicle (males)	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems (females)	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury (Concussions)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>

Please continue on the other side.

Convulsions or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to lose Consciousness or faint	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Weight Problem		
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	(under or overweight)	<input type="checkbox"/>	<input type="checkbox"/>

Please explain briefly any "YES" answers. _____

FAMILY HISTORY Has anyone in your family (Parents, siblings, grandparents) ever had:

	NO	YES		NO	YES
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Allergic Rhinitis (hay fever)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease (high cholesterol, heart attack < 50 years old)	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>

Please explain briefly any "YES" answers. _____

MEDICATIONS

	NO	YES
Are you on Birth Control Pills?	<input type="checkbox"/>	<input type="checkbox"/>
Do you regularly use any Prescription Medications?	<input type="checkbox"/>	<input type="checkbox"/>

ALLERGIES

	NO	YES
Do you have any Allergies to medication?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any Allergies to food?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any Allergies?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain briefly any "YES" answers. _____

IMMUNIZATIONS (record dates)

* Immunization records can be sent separately. You may need to obtain them from your physician, or your high school nurse may have a record of them

Last Tetanus (Recomend Tdap)	_____	Hepatitis B-Dose 1	_____
MMR		Dose 2	_____
Dose 1	_____	Dose 3	_____
Dose 2	_____	HPV - Dose 1	_____
Meningitis (Strongly Recommended by PSU)	_____	Dose 2	_____
Varicella (chicken pox)	_____	Dose 3	_____

I certify that the above information is to the best of my knowledge accurate and true.

Student's Signature _____ Date _____

**Plymouth State University
Health Service, 16 Merrill Street, Plymouth, NH 03264**

Consent for permission to provide medical treatment.

I do hereby give the professional staff of Health Services permission to provide medical treatment for myself.

Student's Signature _____ Witness Signature _____ Date _____

