



Health Questionnaire

This form is required and must be completed by all students

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:

Do you have health insurance coverage? YES__ NO__ Name of Health Insurance Co. _____

Policy/ID Number _____ Subscriber's Name _____

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

If you checked NO and are interested in what individual policies may be available, check the Health Services website at:
<http://www.plymouth.edu> for a list of local insurance agencies.

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"/>	Broken Bone(s)	<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"/>	Joint Problems (Arthritis)	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury (Concussion)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>

Please continue on the other side.

	NO	YES	Date started at PSU	NO	YES
Convulsions or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems (female)	<input type="checkbox"/>	Month/Year <input type="checkbox"/>
Tendency to lose Consciousness or faint	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Loss of function or absence of one testicle (male)	<input type="checkbox"/>	<input type="checkbox"/>	Weight Problem (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"/>
Do you take any vitamins or nutritional supplements?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain briefly any "YES" answers: _____

ALLERGIES

	NO	YES
Do you have any medication allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any food allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any seasonal or environmental allergies?	<input type="checkbox"/>	<input type="checkbox"/>

IMMUNIZATIONS (record dates)

* A copy of immunization records can be sent separately and is preferred. You may obtain them from your physician or your high school nurse may have a record.

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

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

Student's Signature _____ **Date** _____

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** _____

Return form to:

Plymouth State University
Health Services, 17 High St., MSC 45, Plymouth, NH 03264