Date started at PSU_____

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 Asthma)	☐	☐	Hospitalizations	☐	☐
Smoke Cigarettes	☐	☐	Any Activity Restrictions		
Trouble Breathing	☐	☐	(in the past 5 years)	☐	☐
Heart Disease or Murmur	☐	☐	Psychological or Emotional		
Rheumatic Fever	☐	☐	Problems	☐	☐
Chest Pain with Exercise	☐	☐	Cancer or Impaired Immunity	☐	☐
Dizziness or Fainting with Exercise	☐	☐	Broken Bone(s)	☐	☐
Hypertension	☐	☐	Neck or Back Injuries	☐	☐
Ulcer or Stomach Irritation	☐	☐	Frequent Backaches	☐	☐
Constipation or Chronic Diarrhea	☐	☐	Knee Injury	☐	☐
Mononucleosis	☐	☐	Recurrent Ankle Injuries	☐	☐
Hernia	☐	☐	Joint Problems (Arthritis)	☐	☐
Anemia	☐	☐	Head Injury (Concussion)	☐	☐
Diabetes	☐	☐	Hearing Loss	☐	☐
Hypoglycemia	☐	☐	Loss of Vision	☐	☐

Please continue on the other side.

	NO	YES		NO	YES
Convulsions or Epilepsy	☐	☐	Menstrual problems (female)	☐	☐
Tendency to lose Consciousness or faint	☐	☐	Thyroid Disorder	☐	☐
Loss of function or absence of one testicle (male)	☐	☐	Weight Problem (under or overweight)	☐	☐

Please explain briefly any "YES" answers. _____

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

	NO	YES		NO	YES
Diabetes	☐	☐	Asthma	☐	☐
Migraine Headaches	☐	☐	Allergic Rhinitis (hay fever)	☐	☐
Heart Disease (high cholesterol, heart attack < 50 years old)	☐	☐	Cancer	☐	☐
High Blood Pressure	☐	☐	Alcoholism	☐	☐

Please explain briefly any "YES" answers. _____

MEDICATIONS

	NO	YES
Are you on Birth Control Pills?	☐	☐
Do you regularly use any prescription medications?	☐	☐
Do you take any vitamins or nutritional supplements?	☐	☐

ALLERGIES

	NO	YES
Do you have any medication allergies?	☐	☐
Do you have any food allergies?	☐	☐
Do you have any seasonal or environmental allergies?	☐	☐

Please explain briefly any "YES" answers: _____

Please attach a copy of immunization records

By signing this form I understand and agree to the following:

I certify that the information contained in this form is to the best of my knowledge accurate and true.

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

The cost of a visit is covered by the student health fee. However charges may be incurred for supplies and lab tests. These will be billed and paid through my bursar account.

Student's Signature _____ Date _____

Return form to: **Plymouth State University**
Health Services, 17 High St., MSC 45, Plymouth, NH 03264