THOMAS
Health Services

HEALTH RECORD
MEDICAL QUESTIONNAIRE

TO BE FILLED OUT COMPLETELY BY THE STUDENT. This information is confidential and will not be released to anyone without your knowledge and consent. Please answer each question on this form and **mail**: Health Center, Thomas College, 180 W. River Rd., Waterville, ME 04901 or **fax:** (207)859-1126 or **email**: healthctr@thomas.edu. This form is not valid without your signature at the bottom.

NAME (*please print*)_____
LAST FIRST MIDDLE

HOME ADDRESS_____
STREET CITY STATE ZIP COUNTRY

HOME PHONE #_____ (include area code) CELL PHONE #_____ (include area code) BIRTH DATE ___/___/___ Month Day Year

1. PARENT/GUARDIAN NAME_____ PHONE_____ (include area code)

2. PARENT/GUARDIAN NAME_____ PHONE_____ (include area code)

NAME OF EMERGENCY CONTACT (other than Parent/Guardian) _____

RELATIONSHIP_____ PHONE #_____ (include area code)

Permission is hereby granted for the emergency use of anesthesia and emergency medical treatment for applicant under the age of 18. Every effort will be made to contact parents - this permission will be used only in emergency. Permission is also given to administer flu vaccine if requested by student.

Signature_____
PARENT OR GUARDIAN

Each student must be covered by medical insurance. Policy name & number_____

Personal Medical History

Do you have any problems with any of the following diseases or conditions? Please check all that apply.

Head injury w/unconsciousness _____
Migraine headache _____
Seizure disorder/epilepsy _____
Sinusitis _____
Asthma _____
Tuberculosis _____
Heart murmur, heart disease _____
High blood pressure _____
Stomach or intestinal problem _____
Orthopedic problems _____
(including back problems)

Menstrual problems _____
Anemia _____
Tumor, cancer, cyst _____
Rheumatic Fever _____
Diabetes _____
Alcohol/drug problem _____
Eating disorder _____
Frequent depression _____
(anxiety, panic attacks)
Sickle Cell Trait _____

Glasses _____ Contacts _____ Both _____

Allergies
Medications (*penicillin, sulfa, or other*):
_____
Foods:_____
Other:_____

Medications – list any you are taking now:
_____
_____

Surgeries (type and date): _____

Has your physical activity been restricted during the past five years? __ No __Yes (Give reasons and duration in REMARKS SECTION.)

Have you had any illness or injury or been hospitalized other than already noted? __No __Yes (Give details in REMARKS SECTION.)

REMARKS SECTION - Please list here any physical or psychological problems which are current or on-going.
_____
_____
_____

Student's Signature: _____ Date_____

Updated 5/20