Thomas COLLEGE Health Center

HEALTH RECORD
MEDICAL QUESTIONNAIRE

SIDE 1: 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** to: Health Center, Thomas College, 180 W. River Rd., Waterville, ME 04901or **fax** to: (207)859-1126 This form is not valid without your signature at the bottom.

NAME_____
LAST FIRST MIDDLE

HOME ADDRESS_____
STREET CITY STATE ZIP COUNTRY

HOME PHONE #_____ CELL PHONE #_____ BIRTH DATE ___/___/___
(include area code) (include area code) 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 applicants under the age of 18. Every effort will be made to contact parents/guardian - 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	_____	Menstrual problems	_____	Glasses_____	Contacts_____ Both_____
Migraine headache	_____	Anemia	_____		
Seizure disorder/epilepsy	_____	Tumor, cancer, cyst	_____	**Allergies** (cause & symptoms)	
Sinusitis	_____	Rheumatic Fever	_____	Medications (penicillin, sulfa, or other)	
Asthma	_____	Diabetes	_____		
Tuberculosis	_____	Alcohol/drug problem	_____	Other:	
Heart murmur, heart disease	_____	Eating disorder	_____		
High blood pressure	_____	Depression	_____		
Stomach or intestinal problem	_____	Anxiety disorder	_____	**Medications** – list any you are taking:	
Orthopedic problems (including back problems)	_____	Sickle Cell Trait	_____		

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.)

Do you have a history of mental health or substance use disorder or treatment? ❒ 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_____

5/2026