



Comprehensive Student Health Report

We recognize that all of the information on this form is personal health information and will only be shared with appropriate college officials on a need-to-know basis. It is important that the student complete all five pages of this form in order to assist us in providing the best medical care. You can type information directly on the form, print it and mail it to the Center for Health and Wellness, Keene State College, 229 Main Street MS 2802, Keene NH 03435.

Part I: General Information

Name Last First Middle Maiden Birth Date
Home Address No./Street/Apt. City State Zip Home Phone
Marital Status Children? Cell Phone
Veteran N Y Branch Yrs. of Service Sex F M
Transfer Student? Y N Previous College Citizenship
Place of Birth Student ID No.

Athletic Status – Are you planning on playing a competitive sport here at Keene State College? Yes or No

If yes, which sport? If you responded "yes" to this question, this form will be shared with the Athletic Training Department.

Emergency Contact

Name Relationship
Address: Street City State Zip
Phone: Home Office Cell

Family History

Are you adopted? yes no

Table with 6 columns: Name, Occupation, Year of birth, State of health, Age of death, Cause of death. Rows include Father, Stepfather, Mother, Stepmother, Sibling, Sibling, Sibling.



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Student Information

Name Last First Middle

Family History

Have your blood relatives had any of the following?

Table with columns for Y, N, Relationship and rows for various conditions like Alcoholism, Allergies, Arthritis, Asthma, Cancer, Cholesterol, Depression, Diabetes, Epilepsy, Blood/Clotting Disorder, Emotional problems, Headaches, Heart disease, High blood pressure, Kidney disease, Intestinal problems, Learning disabilities, Lung disease/TB, Stomach disease, Stroke.

Part II: Medical History

1. Describe any ongoing health problems or conditions requiring medical care.

Have you ever had any of the following:

Form with 8 questions and checkboxes for Yes/No, including Adverse or allergic reaction, Allergic reaction to food, Mononucleosis, Chicken pox, Operation or serious injury, Hospitalization, List any medications you use.

Have you ever had or been treated for any of the following:

Form with 6 questions and checkboxes for Yes/No, including Serious disease of eyes, ears, nose, or throat; Frequent or severe headaches, migraines, or convulsions; Lung disease, asthma, persistent cough, or shortness of breath; High blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of heart or blood vessels; Frequent or severe abdominal pain, hepatitis, problems with bowel movements, rectal bleeding, or other intestinal problem; Sugar, protein, or blood in urine, or bladder or kidney problem.



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Medical History continued

20. A sexually transmitted infection (STI)
21. Diabetes, thyroid, or other endocrine disorder
22. Anemia, clotting, or other disorder of the blood
23. Bone, joint, or muscle problem; back pain; arthritis; physical deformity or paralysis
24. Hay fever, hives, or other allergy
25. Severe acne, eczema, or other skin disorder
26. Cancer or other tumor
27. A disorder not listed above (specify)

Do you...

28. Know your blood type? Type:
29. Smoke or chew tobacco? Amount:
30. Have a special diet? (Explain)
31. Drink alcoholic beverages? (Specify type and number of drinks per week)
32. Use recreational drugs? (Please specify)

Women Only

33. Have you ever had a menstrual disorder or disorder of the female organs?
34. Have you had a pelvic exam and Pap smear? (Specify dates and findings of your most recent exam)
35. Do you do a monthly breast self-exam?
36. Do you take birth control pills?
37. Do you use any other form of contraception? (Please specify)
38. Do you use condoms?

Men Only

39. Do you use condoms?
40. Have you ever had any disorder of the penis, testicles, or prostate?
41. Do you do a monthly testicular self-exam?

If you are interested in learning more about the services offered through the Center for Health and Wellness, please visit our website at www.keene.edu/chw.



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Part III: Mental Health History

1. Describe any medical or mental health problems or conditions that have required psychological care.

Have you had or experienced any of the following treatment. Yes No Details: Identify questions by number, include diagnosis, age or dates, and

- 2. Depression
3. An anxiety disorder
4. An eating disorder
5. Bipolar disorder
6. Obsessive-compulsive disorder
7. An anger management issue
8. PTSD
9. ADD/ADHD
10. A suicide attempt
11. Thoughts of suicide
12. Self harm (e.g., cutting)
13. A sleep disorder
14. Panic disorder
15. A learning disability
16. An anti-social or conduct disorder
17. Alcohol or substance abuse or dependence
18. Are you now taking or have you ever taken medication for any of the above?

(specify medication and dates)

- 19. Have you been hospitalized for a psychiatric disorder?
20. Have you been treated for alcohol and/or drug addiction? (specify dates)
21. Are you currently being treated by: a psychiatrist, a psychotherapist (counselor, psychologist, social worker), or other mental health professional?



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Part IV: General Wellness Information

Student Information

Name _____

Last

First

Middle

At the Center for Health and Wellness we recognize the impact that regular physical activity (walking, running, playing sports, working out) can have on a person's overall physical and mental health. Please indicate how much time and what type of physical activity/activities you participate on a weekly basis.

College students often experience an array of health issues and /or concerns. Some of the more common topics we see at the Center are stress, weight concerns, fitness and food choices, and sleep challenges, choices around the issues of alcohol, tobacco and other drugs as well as sexual activity. Please identify what issues you may have concerns about as you begin your academic career at Keene State College.
