



Center for Health and Wellness

Promoting Health and Wellness that Facilitates a World of Possibilities

Keene State College
229 Main Street
Keene, NH 03435-2802
603-358-2450
603-358-2444 fax
www.keene.edu/chw

Comprehensive Student Health and Disability Report

Part I: General Information

All information disclosed on this form will be kept confidential and will be shared with appropriate College personnel on a need-to-know basis only. Please return your completed report to Health Services, using the enclosed return envelope.

Name _____ Birth Date _____
 Last First Middle Maiden

Home Address _____ Home Phone _____
 No./Street/Apt. City State Zip

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 _____ Soc. Sec. No. _____

Emergency Contacts

Primary: Name _____ Relationship _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Home _____ Office _____ Cell _____

Secondary: Name _____ Relationship _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Home _____ Office _____ Cell _____

Health Insurance Company _____ Policy Number _____ Policy Holder _____

Family History

Are you adopted? yes no

Name	Occupation	Year of birth	State of health	Age of death	Cause of death
Father					
Stepfather					
Mother					
Stepmother					
Sibling					
Sibling					
Sibling					



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Family History

Have your blood relatives had any of the following?

	Y	N	Relationship		Y	N	Relationship
Alcoholism/drug abuse				Emotional problems			
Allergies				Headaches			
Arthritis				Heart disease			
Asthma				High blood pressure			
Cancer				Kidney disease			
Cholesterol problem				Intestinal problems			
Depression				Learning disabilities			
Diabetes				Lung disease/TB			
Epilepsy/convulsions				Stomach disease			
				Stroke			

Part II: Medical History

This form (all pages) must be completed by the student.

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

Have you ever had any of the following:

2. Adverse or allergic reaction to any medication
3. Allergic reaction to food, insect bites, or other
4. Mumps
5. Mononucleosis (Mono)
6. German measles (Rubella)
7. Hard measles (Rubeola)
8. Chicken pox
9. Tuberculosis
10. Operation or serious injury
11. Hospitalization
12. X-ray therapy to the head or neck
13. List any medications you use:

Yes No

- | | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

Details: Identify question by number, include diagnosis, age or dates, and treatment.

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

14. Serious disease of eye, ears, nose, or throat
15. Frequent or severe headaches or convulsions, or a severe head injury
16. Lung disease, asthma, persistent cough, or shortness of breath
17. High blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of heart or blood vessels
18. Frequent or severe abdominal pain, hepatitis, problems with bowel movements, rectal bleeding, or other intestinal problem
19. Sugar, protein, or blood in urine, or bladder or kidney problem

- | | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |



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Medical History continued

- | | Yes | No | |
|---|--------------------------|--------------------------|-------|
| 20. A sexually transmitted infection (STI) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 21. Diabetes, thyroid, or other endocrine disorder | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 22. Anemia or other disorder of the blood | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 23. Bone, joint, or muscle problem; back pain; arthritis; physical deformity or paralysis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 24. Hay fever, hives, or other allergy | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 25. Severe acne, eczema, or other skin disorder | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 26. Cancer or other tumor | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 27. A disorder not listed above (specify) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Do you...

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

Women Only

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

Men Only

- | | | | |
|--|--------------------------|--------------------------|-------|
| 38. Have you ever had any disorder of the penis, testicles, or prostate? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 39. Do you do a monthly testicular self-exam? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Do you have any questions about your health or other matters you would like to discuss with a Health Services staff member?

- | | | |
|--------------------------|--------------------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
|--------------------------|--------------------------|-------|

I hereby certify that the above is complete to the best of my knowledge.

Signed _____

Date _____



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Part IV: Disability Information

All information disclosed on this form will be kept confidential and will be shared with appropriate College personnel on a need-to-know basis. Please return your completed report to Health Services, using the enclosed return envelope.

The Office of Disability Services, located at the Elliot Center in Elliot Hall, addresses the academic needs of students with documented physical, psychological, and learning disabilities. Accommodations may include, but are not limited to, note takers, readers, sign language interpreters, extended time for testing, books in alternative format, and use of assistive technology.

Accommodations are available upon request to those students entitled to them under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. Filling out this form does not automatically qualify you for accommodations. To receive services, a student must provide appropriate documentation of his or her disability. Documentation of the disability should be forwarded directly to Jane Warner, Disability Service Coordinator, MS 2609. If your documentation is incomplete or inadequate for our purposes, you may be granted interim accommodations until more detailed or timely documentation can be arranged.

Student Information

Name _____
Last First Middle

1. What is the nature of your disability? _____

2. How and when was your disability diagnosed and documented? _____

3. What types of accommodations have you used? _____

4. What accommodations are you requesting at Keene State College? _____

5. Are there any new accommodations you anticipate requesting? If so, please specify. _____



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Part V: General Wellness Information

All information disclosed on this form will be kept confidential and will be shared with appropriate College personnel on a need-to-know basis only. Please return your completed report to Health Services, using the enclosed return envelope.

Student Information

Name _____
Last First Middle

Please indicate if you regularly engage in any of the following forms of exercise:

- Running
 - Walking
 - Working out
 - Swimming
 - Hiking
 - Skiing/snowboarding
 - Yoga
 - Team sports (specify) _____
 - Other (specify) _____
-

What are your major health concerns, if any, as you come to Keene State College?

- Stress
 - Weight loss/gain/maintenance
 - Fitness
 - Healthy eating
 - Getting enough sleep
 - Avoiding illness
 - Avoiding tobacco
 - Avoiding alcohol
 - Avoiding other drugs
 - Other (specify) _____
-

What kinds of health-oriented groups would you like to see at Keene State College?

- Weight Watchers
 - Alcoholics Anonymous
 - Walking club
 - Running club
 - Meditation group
 - Other (specify) _____
-