Jamestown Community College
Residential Student Health History
Required

In order to better assist your medical needs, please answer the following questions as accurately as possible. Please Note: This information is confidential, housed in the Health Center, and will not be released without your permission.

Name_____ DOB_____ J#_____

On-Campus Address_____ Phone:_____

Primary Physician:_____ Phone:_____

Emergency Contact:

Name_____ Relationship_____

Home Phone_____Cell _____ Work _____, ext._____

Personal Medical History
Please answer yes or no below if you have had or are currently under treatment for any of the following:

Alcoholism	____	**Emphysema**	____	**Muscular Dystrophy**	____
Anemia	____	**Emotional Problems**	____	**Peptic Ulcer**	____
Anorexia	____	**Epilepsy**	____	**Seizures**	____
Arthritis	____	**Gall Bladder Disease**	____	**Severe Menstrual Cramps**	____
Asthma	____	**GERD**	____	**STD**	____
Back Disorder	____	**Hearing Impaired**	____	**Skin Disorder**	____
Bronchitis, Chronic	____	**Heart Disease**	____	**Thyroid Disease**	____
Bulimia	____	**Hepatitis**	____	**Tuberculosis**	____
Cancer	____	**High Blood Pressure**	____	**Visually Impaired**	____
Cerebral Palsy (CP)	____	**Hypoglycemia**	____	**Other**	____
Colitis/Irritable Bowel	____	**Kidney Disorder**	____		
Cystic Fibrosis	____				
Deafness	____	**Low Blood Pressure**	____		
Depression	____	**Migraine Headaches**	____		
Diabetes	____	**Multiple Sclerosis**	____		

Please explain any"YES"answers_____
_____
Any serious injuries?_____ If yes, explain_____

Allergies: (An allergy is a skin rash, hives, joint pain, swollen glands, stuffy nose and/or fever after exposure to something to which you're allergic).
Do you have any allergies? Yes____ No____
If yes, please list all allergies: _____
_____

Medications: Do you take any medicine, regularly? Yes ____ No ____ If yes, check those below.

Allergy Shots	___	Aspirin	___	Diabetic Pill	___	Heart Rhythm Med	___	Pain Pill	___
Antacid	___	Asthma Meds	___	Diuretic	___	High Blood Pressure	___	Sleeping Pill	__
Antidepressant	___	Birth Control	___	Epilepsy Meds	___	Insulin	___		
Antihistamine	___	Blood Thinner	___	Headache Meds	___	Laxative	___		

Prescription Medicine_____

Disability:

Any permanent Physical Disability? If Yes, what? _____

Do you use any devices? (i.e.: wheelchair, crutches, other)? _____