SUNY Sullivan
Student Health Services
112 College Road
Loch Sheldrake, NY 12759
(845) 434-5750 ext. 4247
Fax: (845) 434-3628
Email: Healthservices@sunysullivan.edu

REQUIRED HEALTH FORM
Please Return to Health Services

Medications and Medical History

Name:_____ (please print)

Allergies: No___ Yes___ To What:_____

Emergency Contact:_____ Relationship:_____

Phone:_____ Mobile Phone:_____ Work:_____

Primary Physician:_____ Phone:_____

Fax:_____ Address:_____

Current Medications: Please list any medication that you are currently taking. Include non-prescription and vitamins or supplements. If you need more space, please continue on the back of this form.

Name of Medication	Dosage	Months/Years on Medication

Past Medical History: Do you now have or have you ever had: (please check each)

___Diabetes
___High Blood Pressure
___High Cholesterol
___Hypothyroidism
___Goiter
___Cancer (type_____)
___Leukemia
___Psoriasis
___Angina
___Heart Problems
___Head Injury
___Heart Murmur
___Pneumonia
___Pulmonary Embolism
___Asthma
___Emphysema
___Stoke
___Epilepsy/Seizures
___Cataracts
___Kidney Disease
___Kidney Stones
___Bleeding Disorder
___Crohn's Disease
___Colitis
___ COVID-19
___Anemia
___Jaundice
___Hepatitis
___Stomach or Peptic Ulcer ___Rheumatic Fever
___Tuberculosis
___HIV/AIDS
___Other (please explain)
___Sickle Cell Disease