



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)

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer (type _____) | <input type="checkbox"/> Stoke | <input type="checkbox"/> Stomach or Peptic Ulcer |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Other (please explain) |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Sickle Cell Disease |