College of Charleston
Student Health Services Health Form
181 Calhoun Street
Charleston, SC 29424
Phone 843-953-5520 Fax 843-953-6377

Student ID Number

Last Name (Please Print) First Name Middle Preferred Name/Pronoun Student phone #/cell #

Home Address City/Town State/Country Zip Code

Emergency Contact Name Relationship Address

Emergency Contact Main Phone Emergency Contact Business Phone

Biological Sex (Male/Female) Gender Identity (Male, Female, Trans Male (F to M),Trans Female (M to F), Genderqueer, Additional or Other, Choose not to disclose)

Sexual Preference (Heterosexual, Lesbian, Gay or Homosexual, Bisexual, Something else, Don't know, Choose not to disclose, Asexual)

Marital Status Date of Birth Month/Year Starting at C of C

Family History **Family History**

	Age	State of Health	Occupation	Age of Death	Cause of Death		Yes	No	Relationship
Father						Respiratory Disease/Asthma			
Mother						Diabetes			
Brothers						Kidney Disease			
						Heart Disease			
						Cancer			
Sisters						Depression/Anxiety/Bipolar Disorder (please circle)			
						TB			
						Alcohol/Drug abuse			
						Blood clots/Clotting disorder			

Personal Medical History *(Please use section below to comment on "Yes" answers)*

Illness/Injury	Yes	No	Year	**Illness/Injury**	Yes	No	Year	**Illness/Injury**	Yes	No	Year	**Surgery List below**	Year
Alcohol Abuse				Drug Abuse				Mono				Wisdom Teeth	
Anemia				Epilepsy/Seizures				Abnormal Pap Smear				Appendectomy	
Asthma/Lung Disease				Head injury / Concussion				Pneumonia				Tonsils/Adenoids	
Bleeding problem				Hearing loss				Rheumatoid Arthritis MS/Lupus				Hernia	
Blindness				Heart Murmur of other Heart Condition				Seasonal Allergies				Other Surgeries:	
Breast Mass or Surgery				Hepatitis				Sexually Transmitted Infections				**Fractures**	
Cancer				High Blood Pressure				Sickle cell anemia/trait					
Chicken Pox				Hypoglycemia				Thyroid problems					
Clotting Problem				GI Problems				Tobacco use				**Other Health Issues**	
Cystic Fibrosis				Kidney Stones				TB or positive PPD					
Diabetes				Mental/Emotional Problem				UTI/Bladder Problem					
Drug Use				Migraine									

Please comment here on yes answers – use additional pages if needed

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Personal Medical History – Allergies

Allergies	Yes	No	Explanation/List
Drug Allergies			
Insect Bite/Sting Allergies			
Foods			
Latex			

Current Medications: List any drugs, medications, birth control, vitamins, and dietary supplements you use:

Social History

	Yes	No	Explanation/List
Do you smoke cigarettes			
Do you drink alcohol			If yes, how many drinks per week?
Do you use recreational drugs?			
Have you used needles to inject drugs?			

This form must be completed and on file at the Student Health Service (SHS). A physical is not required.

Please include a copy of your insurance card.

For those under 18 years of age, in the event of serious illness or accident, every effort will be made to contact the parent or guardian, however if delayed treatment is deemed detrimental to the patient, authorization for consultation and treatment may not be requested. With this understanding, permission is granted to perform emergency medical or surgical services as deemed necessary.

Expenses for services not routinely covered will be the responsibility of the parent or guardian. Students should have their own health insurance to cover such costs. By signing below the patient consents to the medical treatment provided at SHS.

I have personally supplied the above information and attest that it is true and complete to the best of my knowledge. I understand that the information contained on this form and in my medical records is strictly confidential and will not be released to anyone other than my healthcare provider, without my written authorization unless required by law. If I should be ill or injured or otherwise unable to sign the appropriate medical release form, I give my permission to Student Health Services to release information from my medical record to a physician, hospital, or other medical professional involved in providing me with emergency treatment and/or medical care.

Student Signature

Date

If under 18 years of age:
Parent/Guardian Signature

Date