Medical Services
720 Northern Boulevard • Brookville, NY 11548-1300
516-299-2345 • FAX: 516-299-4113

HEALTH HISTORY

Last Name: ______________________ First Name: ______________________ Middle Initial:_______

LIU ID/SS #: ______________________ Date of Birth: ______/______/______ Age: ____________
mm dd yyyy

Drug Allergies: ______________________ Food Allergies or Intolerance:______________________

Medications (Please include prescription medications and any over-the-counter medications taken daily):

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Past Medical History

- ❏ Frequent Headaches
- ❏ Epilepsy/Seizures
- ❏ Thyroid Disorder
- ❏ Bleeding Disorders
- ❏ Asthma
- ❏ Hypoglycemia
- ❏ High Blood Pressure
- ❏ Heart Disease
- ❏ Frequent Pneumonia
- ❏ Tuberculosis
- ❏ Mononucleosis
- ❏ Stomach/Bowel problems
- ❏ Menstrual Disorders
- ❏ Frequent Ear/ Sinus Infections
- ❏ Diabetes
- ❏ Kidney/Urinary Infections
- ❏ Rheumatic Fever
- ❏ Skin/Bone/Joint
- ❏ Surgery
- ❏ Scarlet Fever
- ❏ Hernias
- ❏ Anemia
- ❏ Cancer
- ❏ Hepatitis
- ❏ Other

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Family Medical History (Please note the family relationship after each checked condition)

- ❏ Diabetes ______________________
- ❏ Tuberculosis ______________________
- ❏ Epilepsy/Seizures ______________________
- ❏ Heart Disease ______________________
- ❏ Hypertension ______________________
- ❏ Asthma/COPD ______________________
- ❏ High Cholesterol ______________________
- ❏ Cancer ______________________
- ❏ Blood Disease ______________________

		Yes	No
A.	Has your physical activity been restricted during the past five years? (Give reasons and duration)		
B.	Have you had difficulty with school or teachers? (Give details)		
C.	Have you received treatment or counseling for a nervous condition, emotional problems, or substance abuse problems? (Give details)		
D.	Have you had any illness or injury or been hospitalized other than already noted? (Give details)		
E.	Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (Other than routine checkups)		

ADDITIONAL COMMENTS

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CHECK IF ANY APPLY:

- ❏ Wheelchair Bound
- ❏ Use of Braces or Crutches
- ❏ Visually Impaired
- ❏ Hearing Impaired
- ❏ Other Handicap

Please briefly explain your special needs: ______________________________

STUDENT AFFIDAVIT: I hereby certify that all the information entered is complete and accurate:

Student Signature: ______________________ Date: ______________

* PARENTAL/GUARDIAN PERMIT *

The law requires that parental permission be obtained so that medical attention can be administered to minors. This consent should be signed by a parent or legal guardian so that procedures judged necessary may be conducted without undue delays. However, no major operation will be performed, except in extreme emergency, without the parents being contacted and fully informed.

I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my son/daughter and also present information concerning his/her medical condition to other responsible college officials when deemed necessary.

Signed: ______________________________ Relationship: ______________________

PLEASE ATTACH A COPY OF BOTH SIDES OF STUDENT'S HEALTH INSURANCE CARD.