THE SAGE COLLEGES

MEDICAL HISTORY FORM

To ensure that this form is complete:

1. Complete side 1 and 2 before going to your Health Care Provider
2. Bring this form to your Provider for a physical exam.
3. Have your Health Care Provider fill in the Examination and Immunization information on this form.
4. Be sure that this form is signed by your Health Care Provider (Pages 2,3 & 4)
5. SIGN the Authorization for Treatment below
6. ***RETURN COMPLETED FORM TO:***
   The Sage Colleges, Wellness Center
   Attn: Immunization Coordinator
   65 1st Street, Troy, NY 12180 FAX 518-244-2262

FOR ADMINISTRATIVE PURPOSES ONLY
Semester: _____ Fall
_____ Spring
_____ Summer
Entering Year: _____
Reviewed By: _____
Date: _____

Check the appropriate college below:
☐ Sage College of Albany 518-292-1917
☐ Russell Sage College 518-244-2261

INFORMATION RECEIVED IS CONFIDENTIAL AND WILL NOT JEOPARDIZE YOUR ACCEPTANCE STATUS OR ACADEMIC STANDING.

Please Print

_____
Last Name First Name Middle Date of Birth

_____
Telephone No. ( ) Student ID #

_____
Home Address (Number and Street) City or Town State Zip Code

_____
Name and Address of Next of Kin

Type of Insurance Policy: Name of Policy _____

Family ☐ Student ☐ Other ☐ Policy Number _____

Authorization for Treatment: I DO HEREBY AUTHORIZE THE SAGE COLLEGE TO PROVIDE FIRST AID TREATMENT AND IN CASE OF EMERGENCY, I AUTHORIZE THE TRANSPORTATION INVOLVED AND THE TREATMENT NECESSARY BY A PRACTITIONER AND/OR AT A HOSPITAL. I SHALL ASSUME ANY EXPENSES WHICH ARISE.

SIGNED _____
(Student)

SIGNED _____
(Parent or Guardian if Student is under 18 years of age)

MEDICAL HISTORY

A. Please check any condition which you or a close family member has or has had. Indicate the relationship.

	Self			Family		
	Y	N		Y	N	Relationship
Alcoholism						
Breast Disease						
Cancer						
Elevated Cholesterol						
Diabetes						
Genetic or Birth Defect						
Heart Attack						
High Blood Pressure						
Sickle Cell Trait or Disease						
Stroke						
I am adopted Yes __ No __						

B. Check Yes or No below if you have ever had any of the following:

	Y	N		Y	N		Y	N
Anemia (Low Iron)			Gallbladder Stones or Disease			Rheumatism or Arthritis		
Asthma			Head Injury w/ Unconsciousness			Scarlet Fever		
Back Problems			Heart Murmur			Severe Weight Gain		
Bronchitis			Hernia			Severe Weight Loss		
Cancer			Infectious Mononucleosis			Sexually Transmitted Disease		
Chicken Pox			Irritable Bowel Disease			Sinus Infection		
Colitis			Jaundice			Skin Disorders		
Depression			Learning Disability			Suicide Attempt		
Diabetes			Liver Disease or Hepatitis			Throat Infections		
Disease/Injury of Joints			Menstrual Irregularities			Thyroid Abnormalities		
Ear Infections			"Nervous" Stomach			Ulcers (Stomach or Duodenal)		
Eating Disorder			Ovarian Cyst			Urinary Tract or Kidney Infections		
Epilepsy/Convulsions/Seizures			Pelvic Infections			Uterine Abnormalities		
Eye Problems			Pneumonia			Vaginal Infections		
Frequent Headaches			Rheumatic Fever			Varicose Veins		

1. List any surgery/operations you have had and dates: _____
   Remarks or additional information _____
   _____
   (Use additional sheet if necessary)

2. Have you been hospitalized overnight? Yes _____ No _____

   Why? _____

3. Do you experience depressions, anxiety, or other emotional problems? Yes _____ No _____

4. Have you received counseling at any time? Yes _____ No _____ Dates _____

   For what? _____

   Are you currently receiving counseling? Yes _____ No _____ Where _____

   For what? _____

5. Please list all medications currently being taken with dosage, frequency and condition for which it is being taken:

Medication	Dosage	Frequency	Condition

6. List ALL ALLERGIES you have:

   Medications: _____

   Foods: _____

   Bees/Insects: Yes ____ No ____ Do you carry an EPI-PEN? Yes ____ No ____

   Environmental: _____

7. Tobacco use: Yes____ No ____ Type/Amount_____

8. Alcohol use: Yes____ No ____ Amount _____ Drug use? Yes ____ No____ Type/Amount _____

9. Do you wear glasses? _____ Contacts?_____

Student's Signature **Clinician's Signature (Acknowledge Review)** **Date**

REPORT OF PHYSICAL EVALUATION

Name: _____DOB _____

Height: _____ Weight: _____ BMI (optional): _____ Pulse: _____ BP: _____

Vision: R 20/_____ L/20 _____ corrected: Y N Urinalysis: Glucose ____ Protein ___ Micro___

Blood work (as applicable) Cholesterol_____ Hg_____ Hct_____

	Normal	Abnormal Findings	Initials
MEDICAL			
Head			
Eyes (lids, conjunctivia, pupils & ocular motion)			
Ears			
Nose/Throat			
Lymph Nodes (Cerv., Ax., Ing.)			
Heart			
Pulses			
Lungs/chest			
Breasts			
Abdomen/Viscera (include hernia)			
Skin			
NEUROLOGIC:			
Gait, Romberg, Muscle Strength/tone, Sensory, Tremor			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Yes	No	
		Any recommendations for special dietary requirements or limitation of physical activity?
		Is this individual under care for a chronic condition or serious illness? If yes, please enclose further information.

Upon completion of a complete physical examination I have found this student capable of participating in a full program of college study, including participation in intercollegiate sports.

Name of Clinician: (print/type) _____ Date: _____

Address: _____Phone: _____

Signature of Physician _____