SAINT MICHAEL'S COLLEGE FOUNDED 1904

Bergeron Wellness Center
Health History Form

Return by mail, email or fax

Bergeron Wellness Center, Saint Michael's College, One Winooski Park, Box 259, Colchester, VT 05439
Email: mmasson@smcvt.edu ◆ Fax: +1.802.654.2699 ◆ Phone: +1.802.654.2234

Name (please print legibly) _____ Date of birth _____

Gender (please circle) M F T

SURGERIES/ HOSPITALIZATIONS

Have you ever had surgery? ❑ YES ❑ NO DATE(S): _____ PLEASE EXPLAIN: _____

_____ _____

Have you ever been hospitalized overnight? ❑ YES ❑ NO DATE(S): _____ PLEASE EXPLAIN: _____

_____ _____

LIST ANY KNOWN TRUE ALLERGIES

Medication: ❑ YES ❑ NO LIST: _____

Food: ❑ YES ❑ NO LIST: _____

Environment: ❑ YES ❑ NO LIST: _____

Other: ❑ YES ❑ NO LIST: _____

LIST ALL MEDICATIONS TAKEN ON A REGULAR BASIS

Medication	Dosage	Frequency	Reason

PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS FORM ---------->

DO YOU OR ANY BLOOD RELATIVES (parents, siblings, grandparents or children only) have a history of any of the following health issues:

_____ Check here if your family health history is unknown and continue to complete your own health history below.

YOU		YOU	RELATIVE	
❑	ADD or ADHD	❑	❑	Alcohol or drug abuse
❑	Anemia	❑	❑	Anxiety
❑	Asthma	❑	❑	Bleeding or clotting disorder
❑	Concussion	❑	❑	Cancer
❑	Eating disorder	❑	❑	Depression
❑	Eye disease or blindness	❑	❑	Diabetes
❑	Hearing loss	❑	❑	Elevated cholesterol or lipids
❑	Hepatitis	❑	❑	Frequent or severe headaches
❑	Liver conditions (chronic)	❑	❑	Gastrointestinal disorder
❑	HIV positive or AIDS	❑	❑	Heart disease
❑	Kidney infection or disease	❑	❑	High blood pressure
❑	Mental health issue	❑	❑	Rheumatoid arthritis
❑	Mononucleosis	❑	❑	Sickle cell trait or disease
❑	Organ absence or abnormality	❑	❑	Stroke
❑	Pelvic infection	❑	❑	Seizure disorder
❑	Pneumonia	❑	❑	Suicide or attempted
❑	Sexually transmitted infection	❑	❑	Thalassemia
❑	Sexual assault or abuse	❑	❑	Thyroid disorder
❑	Tobacco use (cigarette or chew)	❑	❑	Tuberculosis
❑	Urinary tract infection	❑	❑	Other

Please explain checked boxes, as needed _____

_____

_____

Current Medical or Mental Health Providers (Name and phone)

_____

_____

_____

IF YOU ARE UNDER 18 YEARS OF AGE UPON ENTRANCE TO COLLEGE, PARENTAL/GUARDIAN CONSENT IS NECESSARY.

I, _____ (parent or guardian), pursuant to the authority vested in me, do hereby authorize Bergeron Wellness Center of Saint Michael's College to exercise for me and on my behalf, all rights and duties with reference to appropriate emergency medical, psychiatric and surgical treatment, anesthetics, medicines and hospitalization, including care and treatment by any hospital and/or health care provider which they may deem necessary for:

_____ _____ _____

(print student's full name) (parent/guardian's signature) (date)

PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS FORM ---------->