Lasell University Health Services
1844 Commonwealth Avenue
Newton, MA 02466
Tel: (617) 243-2451
Fax: (617) 243-2339

LASELL UNIVERSITY STUDENT HEALTH HISTORY

Athletes: Check here if you plan to participate in varsity sports ☐

Name _____ Date of Birth _____ Gender _____
Last **First**
Home Address _____ City _____ State _____ Zip _____

Home Phone # _____ **Student Cell Phone #** _____
Include Country Code if International Area Code

IN CASE OF EMERGENCY NOTIFY: _____ Phone # _____ Relationship _____

Health Insurance Plan: _____ ID# _____ Group # _____

Health Insurance Plan Address _____ Subscriber Name: _____

CONSENT FOR TREATMENT OF MINORS: ***(Under 18)***

I consent to have my child _____ receive routine care at Lasell University Health Services or local hospital should he/she become ill, injured or require emergency care while at school.

Parent/Guardian's Signature _____ Date _____

FAMILY HISTORY:

RELATION	AGE	IN GOOD HEALTH (YES/NO)	PAST/PRESENT SERIOUS ILLNES	IF DECEASED AGE AT DEATH	CAUSE OF DEATH
Father					
Mother					
Brother/Sister					
Brother/Sister					
Brother/Sister					

PERSONAL HISTORY: ***Please check Yes or No below. If Yes, please give details below*****

	Y	N	AGE		Y	N	AGE		Y	N	AGE		Y	N	AGE
ADHD/ADD				Diabetes				Head injury / Concussion				Panic Disorder			
Allergies				Dizziness / Fainting				Headaches				Seizure disorder			
Alcohol use				Depression				Heart				Skin / Acne			
Anemia				Drug use				Hepatitis				Sleep Issues / Insomnia			
Anxiety				Ear / Nose / Throat				High Blood Pressure				Smoking, # of cigarettes a day____			
Asthma				Eating Disorder				Kidney or urinary				Thyroid			
Bone & Joint				Eye / Vision				Menstrual Problems				Tuberculosis or (+) PPD			
Cancer				Gastrointestinal				Mononucleosis				Other _____			

1. **Are you allergic to any medicines? Yes ☐ No ☐ Which ones?** _____
2. List any food and/or environmental allergies and describe the reaction: _____
3. List all medications that you are taking (prescription, vitamin, and supplements). Name & dose _____
   Reason _____
4. Have you received counseling or been hospitalized for worry, anxiety, depression, alcohol or other drug use, disordered eating or other mental/emotional health care? Yes ☐
   Explain _____
5. Date and type of any hospitalizations, injuries, (athletic & nonathletic), and surgical operations which you have had. _____
6. Are you being followed by a physician for any medical problems? Explain _____

**** Details for any Yes answers above (attach additional pages if necessary):** _____

I hereby certify that the information entered above is complete and accurate.

Date: _____ Student's Signature _____