Bay Path College Health Services
588 Longmeadow Street
Longmeadow, MA 01106
Phone: 413.565.1392
Fax: 413.565.1104
Email: panderso@baypath.edu

HEALTH QUESTIONNAIRE

This form is to be filled out by the student, parents, or guardian of each student who is entering Bay Path College either as a member of the first year class or as a transfer from another college.

PERSONAL INFORMATION

First:	Middle:	Last:
Social Security Number:	Date of Birth:	
Home Phone:	Cell Phone:	
Home Address Street:		
Home Address City:	State:	Zip:

PARENT OR GUARDIAN INFORMATION

Parent/Guardian #1

Name:	Relationship:	
Home Phone:	Cell Phone:	
Home Address Street:		
Home Address City:	State:	Zip:
Work Address Street:		
Work Address City:	State:	Zip:

Parent/Guardian #1

Name:	Relationship:	
Home Phone:	Cell Phone:	
Home Address Street:		
Home Address City:	State:	Zip:
Work Address Street:		
Work Address City:	State:	Zip:

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL PROCEDURES

Required only if student is under 18 years of age

I hereby authorize Bay Path College or their school designee to give permission for routine medical care or emergency medical treatment and/or surgical procedures including transportation to a local hospital by ambulance, if necessary.

I understand the contents of the form I am signing:

Student Name:	Date:
Signature of Parent or Guardian:	Date:

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FAMILY HEALTH HISTORY

	Age	*State of Health*	*Occupation*	*Age of Death*	*Cause of Death*
Father:					
Mother:					
Brothers:					
Sisters:					
Spouse:					
Children:					

Have any of your relatives ever had:			*Relationship*	*Comments*
Alcoholism	☐Yes	☐No		
High Blood Pressure	☐Yes	☐No		
Cancer	☐Yes	☐No		
Heart Disease	☐Yes	☐No		
Diabetes	☐Yes	☐No		
Mental/Emotional Illness	☐Yes	☐No		
Stomach or Intestinal Disease	☐Yes	☐No		
Kidney Disease	☐Yes	☐No		
Epilepsy/Convulsions	☐Yes	☐No		
Tuberculosis	☐Yes	☐No		
Stroke/Blood Clotting	☐Yes	☐No		
Marfan Syndrome	☐Yes	☐No		
Sudden Death (under age 50)	☐Yes	☐No		

PERSONAL HEALTH HISTORY

Past illnesses *If yes, please explain below as appropriate (use extra sheet if necessary)*

1.	Hospitalization (date/reason)	☐Yes ☐No	5.	Emotional Problems	☐Yes ☐No
2.	Surgery (date/reason)	☐Yes ☐No	6.	Psychiatric Treatments	☐Yes ☐No
3.	Serious Accidents	☐Yes ☐No	7.	Other Significant Health Problems	☐Yes ☐No
4.	Serious Illness	☐Yes ☐No			

Have you ever had the following? *If yes, please explain below as appropriate (use extra sheet if necessary)*

8.	Chicken Pox	☐Yes ☐No	11.	Measles	☐Yes ☐No
9.	Tuberculosis	☐Yes ☐No	12.	Scarlet Fever	☐Yes ☐No
10.	Hepatitis (specify type)	☐Yes ☐No	13.	Other (specify)	☐Yes ☐No

If you answered yes to any questions above, please explain below

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PERSONAL HEALTH HISTORY (CONTINUED)

Allergies to medications and/or environmental factors

14. Penicillin	☐Yes ☐No	
15. Other antibiotics?	☐Yes ☐No	
16. Other medications?	☐Yes ☐No	
17. Life threatening reaction to insect bites?	☐Yes ☐No	
18. Life threatening reaction to food, etc.?	☐Yes ☐No	
19. Do you carry an epinephrine kit?	☐Yes ☐No	
20. Are you allergic to cigarette smoke?	☐Yes ☐No	
21. Are you allergic to dust and/or pollen?	☐Yes ☐No	
22. Heart/blood pressure medications	☐Yes ☐No	
23. Tranquilizers/antidepressants	☐Yes ☐No	
24. Insulin?	☐Yes ☐No	
25. Allergy injections?	☐Yes ☐No	
26. Other (please specify)?	☐Yes ☐No	

Lifestyle

27. Do you drink alcohol?	☐Yes ☐No	Drinks per week:
28. Do you smoke?	☐Yes ☐No	Cigarettes per day: Number of years smoked:
29. Do you diet frequently?	☐Yes ☐No	
30. Do you exercise regularly?	☐Yes ☐No	
31. Do you wear a seatbelt?	☐Yes ☐No	

Have you ever had?

32. Migraine headaches (diagnosed by M.D.)	☐Yes ☐No	
33. Epilepsy	☐Yes ☐No	
34. Paralysis or disability	☐Yes ☐No	
35. Thyroid problems	☐Yes ☐No	
36. High blood pressure	☐Yes ☐No	
37. Any heart problems	☐Yes ☐No	
38. Asthma	☐Yes ☐No	
39. Gastrointestinal complaints	☐Yes ☐No	
40. Gallbladder disease	☐Yes ☐No	
41. Head injury or concussion	☐Yes ☐No	
42. Chronic or persistent respiratory infection	☐Yes ☐No	
43. Urinary tract infection	☐Yes ☐No	
44. Gynecological problems	☐Yes ☐No	
45. Sexually transmitted disease	☐Yes ☐No	
46. Disease or injury of the joints	☐Yes ☐No	
47. Insomnia	☐Yes ☐No	

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PERSONAL HEALTH HISTORY (CONTINUED)

48. Dental problems	☐Yes	☐No
49. Kidney disease	☐Yes	☐No
50. Cancer	☐Yes	☐No
51. Fainting or dizziness associated with exercise	☐Yes	☐No
52. Back problems	☐Yes	☐No
53. Anorexia/Bulimia	☐Yes	☐No
54. Mono (diagnosed by M.D.)	☐Yes	☐No
55. Diabetes	☐Yes	☐No
56. High blood pressure	☐Yes	☐No
57. Immune deficiency problems	☐Yes	☐No

CURRENT HEALTH STATUS

58. Height: Weight:		
59. Are you currently in psychiatric counseling?	☐Yes	☐No
60. Are you currently receiving treatment for a medical condition?	☐Yes	☐No
61. Do you require special housing arrangements?	☐Yes	☐No
62. Do you require any special diet?	☐Yes	☐No
63. Have you had any physical or emotional problems that have affected your high school classroom attendance?	☐Yes	☐No
64. Have you had any physical or emotional problems that have affected your college classroom attendance?	☐Yes	☐No
65. Are there any medications you expect to continue while at Bay Path College?	☐Yes	☐No
Please list medications:		
66. Are there any questions in regard to student's health or other concerns, which should be discussed with a member of the staff of Health Services or with a member of the college faculty or administration?	☐Yes	☐No
Please explain (attach additional paper if necessary):		

HEALTH INSURANCE INFORMATION

First:	Middle:	Last:
Social Security Number:		
Address:		
Subscriber's Full Name:	Name of Policy:	
ID#:	Group #:	
Are you choosing the college health insurance policy? ☐Yes ☐No	***If no, you must attach a copy of insurance card***	

CERTIFICATION OF ACCURACY

I certify that this information is accurate and correct to the best of my knowledge and has not been misrepresented.

Student Name:	Date:
Signature (of Student if 18 or older or guardian if under 18):	Date:

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