NEWTON-WELLESLEY HOSPITAL
2014 Washington Street
Newton, Massachusetts 02462

PATIENT IDENTIFICATION AREA

Health Services at Wellesley College provided by Newton-Wellesley Collegiate Health

NEW STUDENT HEALTH HISTORY and QUESTIONNAIRE

To be completed by student

Student Name _____

DOB (mm/dd/yy)_____ Anticipated Graduation Date:_____

MEDICAL HISTORY: please indicate if you have/had any of the following diagnoses

	YES	Currently active? (if not active, please indicate date of resolution)	Comments
ADHD/ADD			
Anxiety			
Asthma			
Concussion			
COVID-19		Date of Confirmed Testing:	
Depression			
Diabetes (indicate Type)			
Eating disorder (specify)			
Irritable Bowel Syndrome			
Migraines			
Mononucleosis			
Seasonal Allergies			Receiving Immunotherapy?
Seizures/Epilepsy			
Thyroid Disorder			

Health Services provided by Newton-Wellesley Collegiate Health * 106 Central St. Wellesley, MA
Tel 781-283-2810 * Fax 781-283-3693

059750 5/2020

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The above list is not comprehensive. Please list any other chronic medical conditions for which you have received care. Please indicate whether issue is currently active. *Please include behavioral health diagnoses.*

_____

_____

_____

_____

Have you ever been hospitalized for a physical problem?
Explain_____

_____

Have you ever been hospitalized for a mental health problem?

Explain_____

_____

Are you currently seeing any Specialists (including therapist, nutritionist)?

Specify_____

_____

Do you require any physical/mental health accommodations that you would like us to be aware of?

Explain_____

_____

Please list any medications that you take:

_____

_____

_____

_____

_____

Please list any allergies (meds, food, substances):

_____

_____

_____

Do you carry an EpiPen? **Yes / No**

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FAMILY HISTORY: Including any medical or behavioral health diagnoses (see next page)

☐ Adopted/Unknown

Some examples of pertinent family history:

- Cancer (especially breast, colon, ovarian, skin)
- Diabetes
- Heart Disease, Heart attacks (especially <age 50)
- Thyroid issues
- High Blood Pressure
- High Cholesterol
- Kidney or Liver Problem
- COVID- 19
- Alcohol or Substance Abuse
- Depression
- Anxiety
- Bipolar Disorder

	Alive? (age)	Deceased? (age)	Diagnoses
MOTHER			
FATHER			
BROTHER/SISTER			
BROTHER/SISTER			
BROTHER/SISTER			
PATERNAL GM			
PATERNAL GF			
MATERNAL GM			
MATERNAL GF			
OTHER			

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SOCIAL HISTORY

Do you exercise? How often?_____
Have you ever struggled with over -exercise?_____

	Y/N	How much/how often?	Quit date (if applicable)
Have you regularly smoked cigarettes?			
Have you regularly smoked marijuana?			
Have you regularly 'vaped'?			
Have you regularly used alcohol?			
Have you used other drugs? (specify)			
Have you every misused prescription drugs? (specify)			

Best email address to contact you:_____

Best phone number to contact you:_____

****

I certify that the information provided is complete and accurate

STUDENT SIGNATURE (Required)_____

Date _____ **Time** _____

Name/Address of Primary Care Physician:

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