STUDENT HEALTH SERVICES
80 Fifth Avenue, 3rd Floor
Tel: 212.229.1671 option 2, Fax: 212.598.0059

THE NEW SCHOOL

STUDENT HEALTH SERVICES MEDICAL HEALTH HISTORY

Today's Date: _____

Legal Name: (Last)_____ ___ (First)_____ Date of Birth: ____/____/_____
MONTH DAY YEAR

Preferred Name _____ Gender_____ Preferred Pronoun: _____

New School ID: _____ International Student? Yes No Country of Birth _____

Preferred Phone Number: _____ Alternative Phone Number: _____

Email Address: New School: _____ Other: _____

Division: Parsons Lang Social Research Drama Jazz Mannes Public Engagement Other

Degree Anticipated: Associate's Bachelor's Master's Doctorate Other

Expected Graduation Date: _____ If you live in a New School residence hall, which one? _____

Current Local Address: Street: _____Apt. _____

City: _____ State: _____ Zip Code: _____

Are you enrolled in the Aetna (New School) Student Health Insurance Plan? Yes No

If yes, what is your Aetna insurance identification number? **W**_____

<u>If you answered no, please provide your health insurance information below:</u>

Insured's name if different from your own (i.e., if you are under your parents plan) _____

Name of insurance company/plan name _____

Identification number:_____ Group/ Policy number _____

Private Physician/ Healthcare Provider: Name: _____Phone: _____

Private Mental Healthcare Provider: Name: _____Phone: _____

Parent/Guardian: Name:_____ Phone: _____

Address: _____ City: _____ State: _____ Country :_____

EMERGENCY CONTACT (if different from above):

Name:_____ Relationship:_____

Phone: _____ **Address**: Street _____Apt._____

City_____ State/Country _____ Zip Code _____

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MEDICAL SERVICES STUDENT INTAKE

Name _____ Date of Birth ____/____/_____
(Last) (First) MONTH DAY YEAR

Please list medication allergies below:

Please List food and environmental allergies below:

Please list all prescription medications, vitamins or herbal supplements you currently take:

Please check below If **YOU** HAVE ever had any of the following:

Asthma	Yes	No	Drug/Alcohol Problem	Yes	No
Attention Deficit Disorder (ADHD)	Yes	No	Eating Disorder	Yes	No
Cancer/Leukemia	Yes	No	Eczema/Psoriasis	Yes	No
Depression	Yes	No	Heart Problem	Yes	No
Undescended Testicle	Yes	No	Chronic Insomnia	Yes	No
Diabetes	Yes	No	High Blood Pressure	Yes	No
Other (please describe):	Yes	No	Other (please describe):	Yes	No

If you have ever been hospitalized, please describe below:

REASON FOR HOSPITALIZATION:	**YEAR**

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Name _____ Date of Birth ____/____/_____
(Last) (First) MONTH DAY YEAR

If you have ever had surgery, please describe below:

Type of surgery:	**YEAR**

For females:
When was your most recent women's health examination/pap smear? Date: _____ Never □ Not sure □
Have you ever had an abnormal Pap Smear? Yes □ When? _____ No □ I have not had a pap smear □
Do you regularly examine your breasts for lumps? Yes □ No □
Do you have questions about the Breast self-exam? Yes □ No □
If you are over age 40, when was your most recent mammogram? Date _____

For males:
When was your last routine physical examination? Date _____
Do you regularly examine your testicles for lumps? Yes □ No □
Do you have questions about the testicular self-exam? Yes □ No □

Please check below if you have had the following immunizations/illnesses:

Vaccine Name	**Yes**	**Dates (if known)**	**No**
Measles, Mumps, Rubella (MMR) Vaccine Measles □ Mumps □ Rubella □ infection	□ □	1st)_____ 2nd) _____	□ □
Meningitis	□		□
Varicella Vaccine Chicken Pox Infection	□ □		□ □
Hepatitis B	□	1st)_____ 2nd)_____ 3rd)_____	□
Hepatitis A	□	1st)_____ 2nd)_____	□
Tetanus (Tdap)	□		□
Human Papilloma Virus (HPV)	□	1st _____ 2nd _____ 3rd _____	□

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Please check below if you have biological **parents, grandparents or siblings** with any of the following:

Heart attacks/Stroke □	Alcohol/Drug Dependency □	Cancer □ Type:
High Blood Pressure □	Depression □	Other Illness □ Type:
Diabetes □	Eating Disorder □	Other Illness □ Type:
Thyroid Disease □	High Cholesterol □	Other Illness □ Type:

Do you smoke cigarettes?	Yes □ How many per day? _____	No	Quit date____
Do you drink alcohol?	Yes □ How many drinks per week? _____	No □	
Has your alcohol use ever been a concern for you or others?	Yes □	No □	

Do you use any other substances? Yes No If so, please list below:

Name of Substance	How Often	Name of Substance	How Often

Are you on a special Diet (i.e., vegetarian, no gluten, no dairy, etc.)?	YES □	NO □
Do you exercise?	YES □	NO □
If you exercise, what kind of exercise do you do? _____how often?_____ for how many minutes?_____		
Does your weight affect how you feel about yourself?	YES □	NO □
Do you ever eat in secret?	YES □	NO □
Do you ever worry you have lost control over how much or little you eat?	YES □	NO □
Do you ever make yourself vomit because you feel uncomfortably full?	YES □	NO □
Do you ever take laxatives or diet pills to control your weight?	YES □	NO □
Have you recently lost or gained more than 15 pounds in a three month period?	YES □	NO □
Do you wear a helmet when riding a bicycle?	YES □	NO □
Do you wear a seatbelt when riding in a car?	YES □	NO □
Are there any firearms in your home?	YES □	NO □

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Are you sexually active ?	Yes	Not Currently □	No		
Are you currently having any concerns regarding your sexual health?	Yes	No			
How would you describe your sexual orientation/identity?					
Do you have any concerns related to your sexual Identity ?	Yes	No			
Do you have any concerns related to your gender identity?	Yes	No			
If you have ever been sexually active, have your partners been:	Male	Female	Both		
Have you ever had sex in exchange for the following?	Money	Shelter	Food	Drugs	Other
Have you ever had a sexually transmitted infection?	No	Yes (which one(s):			
Have you ever been forced to have sex or been touched in a sexual way against your will?	No	Yes			
Are you interested in being tested for sexually transmitted infections?	Yes	No			
Are you interested in HIV testing?	Yes	No			

If you are involved in a casual or serious sexual relationship, please answer the questions below:

Does your spouse, partner, boyfriend or girlfriend ever:	Yes	No
Accuse you of flirting or cheating?		
Hit, push, choke, kick you or pull your hair?		
Threaten to hurt him/herself, you or someone you love if he/she doesn't get his/her way?		
Try to control what you do and who you see?		
Pressure you sexually, such as touch you or force you to have sex against your will?		
Steal money from you, or intentionally break something valuable of yours, like your iPod or cell phone?		
Spread rumors about you, insult you in front of friends or do anything else that is meant to make you feel bad about yourself?		

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If there is any additional medical or mental health information you would like to share with us, please describe below:

_____

_____

_____

_____

_____

CONSENT FOR TREATMENT

(If under 18 years of age, signature of both parent/guardian and student is required)

I grant permission for The New School Student Health Services (SHS) to provide my routine and acute medical care and to arrange for any emergency care if the circumstances at that time prevent me from being able to make that decision. I understand that by signing this form, I am authorizing SHS medical providers to treat me for as long as I continue to seek care as a New School student or until withdrawing my consent in writing.

Signature of student: _____ Date _____

Signature of parent/guardian: _____ Date:_____
(if under 18 years old)