St. Mary's College of Maryland

Health Services Questionnaire AY 26/27

Legal Name: ________________________________ Preferred Name __________________ Pronouns ___________

Date of Birth: ____ /____ /____ Biologic Sex Assigned at Birth _____________ Student ID: _____________________

If you have healthcare insurance, check all types that apply:

☐ Health ☐ Dental ☐ Vision ☐ Prescription ☐ International health plan (for study abroad students)

Name/address of local pharmacy for prescriptions not available at clinic:

Allergies

Do you have any ***medication and/or food*** allergies? ☐ NO ☐ YES

Do you carry an EpiPen for anaphylaxis? ☐ NO ☐ YES

Please list the medication(s) and/or food(s) **AND** the reactions:

____

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Current Medications

Please list ALL medications you use (***prescriptions, supplements, and over-the-counter products***), including dose and how often they are taken (if none, check box ☐):

____

____

____

Past Medical History

Please list ALL ***medical and psychiatric*** conditions, including year diagnosed and treatment (if none, check box ☐):

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Past Surgical History

Please list ALL ***surgeries and/or hospitalizations***, including years (if none, check box ☐):

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Substance Use

Do you smoke cigarettes/chew tobacco/vape? ☐ NO ☐ YES How much per day? __________________________

Do you drink alcohol? ☐ NO ☐ YES How much per week? _________________________

Do you exercise regularly? ☐ NO ☐ YES How often? _________________________________

Do you use recreational drugs? ☐ NO ☐ YES How much per week? _________________________

List drugs: ____

Family History Check here if adopted:☐ List biological ***PARENTS AND SIBLINGS*** who have/had the following:

			Which Relative: If deceased, list age and cause of death:
High Blood Pressure	☐ NO	☐ YES	______________________________
Diabetes	☐ NO	☐ YES	______________________________
High Cholesterol	☐ NO	☐ YES	______________________________
Stroke	☐ NO	☐ YES	______________________________
Heart Attack	☐ NO	☐ YES	______________________________
Cancer	☐ NO	☐ YES	______________________________
Psychiatric Illness	☐ NO	☐ YES	______________________________

Signature of student: ____ Date: ___________________