Cornell College | STUDENT HEALTH SERVICES

OFFICE USE ONLY

Name _____

Birthdate _____

SSN _____

2026–27
Student Medical History

To be completed by the student and parent/guardian and shared with your medical provider at the time of your physical examination.

Student Information

1

Name: _____ Date of birth: ____ / ____ / ____

Social Security Number: _____ Assigned sex at birth: ◯ Female ◯ Male

Gender identity: ☐ Female ☐ Male ☐ Nonbinary ☐ Transgender

Cornell Student ID Number: _____ Year: ◯ FR ◯ SO ◯ JR ◯ SR

Home phone number: _____ Student phone number: _____

Home mailing address: _____ College address (mailbox#): _____

_____ Sports participating in at Cornell, if any:

_____ _____

_____ _____

Emergency Contacts

2

Contact name: _____ Contact name: _____

Relationship to you: _____ Relationship to you: _____

Daytime phone number: _____ Daytime phone number: _____

Medicines and Allergies

3

Please list all of the prescription and over-the-counter medicines and supplements that you are currently taking:

_____

_____

_____

_____

Do you have known allergies to any medicines?

◯ Yes ◯ No Specify: _____

_____

Do you have allergies to:

☐ Food ☐ Pollen ☐ Stinging insects ☐ Other

Specify: _____

_____

Medical Concerns

4

Do you have any concerns that you would like to discuss with your medical provider? _____

_____

Medical History

5

Have you ever been diagnosed, or do you have a family history of:

Asthma	☐ Myself	☐ Family history	High cholesterol	☐ Myself	☐ Family history
Diabetes Type I	☐ Myself	☐ Family history	Marfan Syndrome	☐ Myself	☐ Family history
Diabetes Type II	☐ Myself	☐ Family history	Seizure disorder	☐ Myself	☐ Family history
High blood pressure	☐ Myself	☐ Family history	Sickle cell trait or sickle cell disease	☐ Myself	☐ Family history
Heart murmur	☐ Myself	☐ Family history			

Any other medical diagnosis: _____

Surgical history: _____

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Bone and Joint Health

Please document any physical injuries that resulted in:

Medical diagnoses include injuries that required: x-rays, MRI, CT, surgery, injections, rehabilitiation, physical therapy, a brace, cast, or crutches

Bone or joint damage: broken or fractured bones, dislocated joints, stress fractures

Restricted participation: sprain, muscle, ligament tear, or tenditis that caused you to miss activities or athletic practice/games

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Bone or joint	Medical diagnoses	Bone or joint damage	Restricted participation
Head	☐	☐	☐
Neck	☐	☐	☐
Shoulder	☐	☐	☐
Upper arm	☐	☐	☐
Elbow	☐	☐	☐
Forearm	☐	☐	☐
Hand/fingers	☐	☐	☐
Chest	☐	☐	☐
Upper back	☐	☐	☐
Lower back	☐	☐	☐
Hip	☐	☐	☐
Thigh	☐	☐	☐
Knee	☐	☐	☐
Calf/shin	☐	☐	☐
Ankle	☐	☐	☐
Foot/toes	☐	☐	☐

Vision Health

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Have you had any problems with your eyes or vision? ◯ Yes ◯ No

Do you wear glasses or contact lenses? ◯ Yes ◯ No

Do you wear protective eyewear? ◯ Yes ◯ No

Reproductive Health

8

Have you ever had a menstrual period? ◯ Yes ◯ No

How old were you when you had your first menstrual period? _____

How many periods have you had in the last 12 months? _____

Heart Health

9

Has a doctor ever ordered a test for your heart? (example: ECG, Echocardiogram) ◯ Yes ◯ No

Does anyone in your family have a heart problem? ◯ Yes ◯ No

Has any family member or relative died of heart problems or sudden death before the age of 50? ◯ Yes ◯ No

Explain any "yes" answers to this section here: _____

Exercise-Related Health

10

Has a doctor ever denied or restricted your participation in sports for any reason? ◯ Yes ◯ No

Do you cough, wheeze, or have difficulty breathing after you exercise? ◯ Yes ◯ No

Do you have headaches with exercise? ◯ Yes ◯ No

Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? ◯ Yes ◯ No

When exercising in the heat, do you have severe muscle cramps or become ill? ◯ Yes ◯ No

Have you ever passed out or nearly passed out DURING exercise? ◯ Yes ◯ No

Have you ever passed out or nearly passed out AFTER exercise? ◯ Yes ◯ No

Have you ever had discomfort, pain, or pressure in your chest during exercise? ◯ Yes ◯ No

Does your heart race or skip beats during exercise? ◯ Yes ◯ No

Explain any "yes" answers to this section here: _____

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Mental/Emotional Health

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Do you ever feel like your stress is unmanageable or out of control? ◯ Yes ◯ No

Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days? ◯ Yes ◯ No

Do you feel like you don't have someone in your life with whom you can openly share concerns? ◯ Yes ◯ No

Do you ever feel unsafe? ◯ Yes ◯ No

Have you ever taken medicine(s) without a doctor's prescription? ◯ Yes ◯ No

Explain any "yes" answers to this section here: _____

Lifestyle Health

12

Do you have any concerns about your weight? ◯ Yes ◯ No

Are you trying to gain or lose weight? ◯ Yes ◯ No

Have you ever taken any supplements to help you gain or lose weight or improve your performance? ◯ Yes ◯ No

Do you have any concerns about your sleep quality or quantity? ◯ Yes ◯ No

Explain any "yes" answers to this section here: _____

Concussion History

13

Have you ever had a head injury/concussion? ◯ Yes ◯ No

If "yes" to concussions, how many have been diagnosed by a physician? _____

Have you ever been knocked out or unconscious? ◯ Yes ◯ No

If "yes" to being knocked out or unconscious, how many times? _____

Signatures

Share this completed form with your medical provider at the time of your physical examination for their signature.

Signature required

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I hereby state that, to the best of my knowledge, my answers to all of the questions on this form are correct.

Signature of student:

	Date

Signature of parent/guardian:

	Date

Signature of medical provider: ◯ MD ◯ DO ◯ PA ◯ NP

	Date

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