Ramapo College of New Jersey
Center for Health and Counseling Services
505 Ramapo Valley Road Mahwah, NJ 07430
Ph: 201-684-7536 Fax: 201-684-7534

Medical History Form

Please complete all pages

Your answers on this form are strictly confidential. This form helps your medical provider provide the best possible care. If you are uncomfortable with any question, you do not need to answer it.

Legal Name (First and last)**:** _____ **Used name:**_____

Phone Number:_____

Student ID: R_____ Age:_____ Date of Birth: _____

Emergency Contact:

Name: _____Relationship_____ Phone #_____

1. What is your gender identity? (Check all that apply)

☐ Male ☐ Female ☐ Transgender Male/Transman/FTM ☐ Transgender Female/Transwoman/MTF

☐ Nonbinary ☐ Gender Queer ☐ Two Spirit ☐ Additional category (please specify):_____

☐ Decline to answer

2. What sex were you assigned at birth? (Check one) ☐ Male ☐ Female ☐ Intersex

3. What pronouns do you use? (Check all that apply)

☐ She/her/hers ☐ He/him/his ☐ They/them/theirs

☐ Other: Please specify: _____

3. Are you Hispanic or Latino? ☐ Yes ☐ No ☐ Unknown

4. What is your racial background? Select all that apply:

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown ☐ Decline to answer

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How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current Medications: Please include all medications, including non-prescription medicines

Medication Name	Dose	Times per day	When started

Allergies or Reactions to Medications:_____

Personal Medical History (Check all that apply):

ADHD/ADD	☐	Eating Disorder	☐	IBS	☐
Acne	☐	Eczema	☐	Kidney Disease	☐
Alcoholism	☐	Food Allergies	☐	Lyme Disease	☐
Anemia	☐	Gallbladder Disease	☐	Malaria	☐
Anxiety Disorder	☐	GERD	☐	Mononucleosis	☐
Arthritis	☐	Gluten Intolerance/Celiac Disease	☐	Post Traumatic Stress Disorder	☐
Asthma	☐	GYN Problem	☐	Seizure Disorder	☐
Autoimmune Disorder	☐	Hearing Loss	☐	Seasonal Allergies	☐
Bi-Polar disorder	☐	Head Injury	☐	Substance Use/ Abuse	☐
Bleeding/Clotting Disorder	☐	Heart Murmur	☐	Suicide Attempt	☐
Cancer	☐	Heart Surgery	☐	Tuberculosis	☐
Cyst	☐	High Blood Pressure	☐	UTI	☐
Diabetes	☐	High Cholesterol	☐	Other:	☐
Depression	☐	Hepatitis	☐	Other:	☐

Surgical History:_____

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Family History (Please indicate if someone from your family suffers from the following):

ADHD/ADD	☐	**Depression**	☐	**High Cholesterol**	☐
Acne	☐	**Eating Disorder**	☐	**Hepatitis**	☐
Alcoholism	☐	**Eczema**	☐	**IBS**	☐
Anemia	☐	**Food Allergies**	☐	**Kidney Disease**	☐
Anxiety Disorder	☐	**Gallbladder Disease**	☐	**Lyme Disease**	☐
Arthritis	☐	**GERD**	☐	**Malaria**	☐
Asthma	☐	**Gluten Intolerance/Celiac Disease**	☐	**Mononucleosis**	☐
Autoimmune Disorder	☐	**GYN Problem**	☐	**Seizure Disorder**	☐
Bi-Polar disorder	☐	**Hearing Loss**	☐	**Seasonal Allergies**	☐
Bleeding/Clotting Disorder	☐	**Head Injury**	☐	**Substance Use/ Abuse**	☐
Cancer	☐	**Heart Murmur**	☐	**Suicide Attempt**	☐
Cyst	☐	**Heart Surgery**	☐	**Tuberculosis**	☐
Diabetes	☐	**High Blood Pressure**	☐	**UTI**	☐
				Other:	☐

Social History:

Tobacco Use (Cigarettes, pipe, cigar, snuff, chew, e-cigs, hookah**)**

☐ Yes ☐ No ☐ Quit

Alcohol Use

☐ Yes : # of drinks per week _____ ☐ No

Is alcohol a concern for you, or are people around you concerned about your drinking? ☐ Yes ☐ No

Drug Use

Do you use any recreational drugs? ☐ Yes ☐ No

If yes, what type do you use and how often:_____

Have you ever used needles for recreational drug use? ☐ Yes ☐ No

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Sexual Activity:

Have you ever been sexually active? ☐ Yes ☐ No

If yes, please check all that apply: ☐ Oral ☐ Vaginal ☐ Rectal

Sexual Orientation:

☐ Bisexual ☐ Gay ☐ Lesbian ☐ Heterosexual/Straight

☐ Pansexual ☐ Queer ☐ Not Listed (please state)_____

Caffeine Intake

☐ Coffee/Tea (How many cups per day)_____

☐ Soda (How many ounces per day)_____

☐ None

Weight & Diet

Are you satisfied with your weight? ☐ Yes ☐ No

How do you rate your diet? ☐ Good ☐ Fair ☐ Poor

Exercise

Do you exercise regularly? ☐ Yes ☐ No

What kind of exercise do you do?_____

How long(minutes) _____? How often?_____

If you do not exercise, why? _____

Seat Belts

Do you always wear your seat belt? ☐ Yes ☐ No

Violence

Is violence at home or here at RCNJ a concern for you? ☐ Yes ☐ No

Have you ever been abused? ☐ Yes ☐ No

If yes, would you like to discuss it today during your visit? ☐ Yes ☐ No

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Signature:_____ **Date:**_____