Center for Health & Counseling Services

Health Services
505 Ramapo Valley Road, Mahwah, NJ 07430-1680
Phone (201) 684-7536   Fax (201) 684-7534
https://www.ramapo.edu/health/

Episodic Medical Form

Name: ________________________________ ID#: R___________________________ Date: ______________

Date of Last Menstrual Cycle: ______________

Please check (✓) any current problems you have on the list below:

General		***Cardiac***		***Preventative Care***	
Fever/ Chills/ Sweats		Cardiac (Heart) Pain		Pregnancy Test	
Change in Energy/ Weakness		Palpitations		STI Testing	
				HIV Testing	
Gastrointestinal		***Respiratory***		Emergency Contraception	
Abdominal Pain		Cough			
Nausea/ Vomiting/ Diarrhea		Wheezing			
		Shortness of Breath		***Other***	
				1.)	
Eyes, Ears, Nose, Throat, Mouth		***Genitourinary***		2.)	
Sore Throat		Vaginal Bleeding		3.)	
Ear Pain/ Muffled Hearing		Vaginal/ Penial Discharge		4.)	
Right		Frequent Urination		5.)	
Left		Pain with Urination			
Both		Increased Urgency in Urination			
Post Nasal Drip				***Has there been any change to your health since your last visit?***	
Nasal Congestion					
Sinus Pressure/ Pain		***Neurological***		Yes	
Eye Redness		Headache		No	
Right		Dizziness		***If Yes, please explain:***	
Left		Change in Vision			
Both					
		Skin			
Musculoskeletal		Rash			
Pain to joint or muscle(s)		Itching			
Chest Wall Pain		Dryness			

MEDICAL CONSENT AND RELEASE OF INFORMATION

I consent and give my permission to receive medical and surgical care deemed appropriate and advisable by the Health Services medical staff. The care may include, but may not be limited to, a health examination, diagnostic procedures, and treatment of illness and/or injury. I authorize the release of my health information as permitted or required under Federal Law or New Jersey State Law. The Center for Health and Counseling Services (CHCS) department is comprised of two units: Counseling Services and Health Services. The professional staff of CHCS operates as a team and as such we may confer with each other as professionally necessary to provide the best possible services to you.

Date: ________________________ Signature: ______________________________________