Icahn School of Medicine at Mount Sinai

Student Health Center

Mount Sinai
One Gustave L. Levy Place, Box 1260
New York, NY 10029-6574

Tel: (212) 241-6023
Fax: (212) 241-8008
studenthealth@mssm.edu

STUDENT HEALTH FORM

STUDENT INFORMATION

Student Name (First, Middle Initial , Last)

Program Entering (please check one)
☐ MD ☐ MD/PhD ☐ PhD ☐ MPH ☐ MSBS ☐ PREP
☐ Clinical Research ☐ Genetic Counseling ☐ Other ___________

Local Address	**City**	**State**	**Zip**

Telephone Number ☐ HOME ☐ CELL	**Email**	**Birthplace**

Gender ☐ Male ☐ Female	**Gender Identity** ☐ Male ☐ Female ☐ Other ___________	**Gender Pronoun** ☐ He ☐ She ☐ They ☐ Name Only ☐ Other_________

Current or Previous Mount Sinai Employee or Student ☐ Yes ☐ No	**Marital Status** ☐ Single ☐ Married	**Date of Birth** ______/ _______/ __________

EMERGENCY CONTACT INFORMATION

Name	**Relationship**

Address	**City**	**State**	**Zip**

Telephone Number
☐ HOME ☐ CELL

PRIMARY CARE INFORMATION

Primary Care Provider

Address	**City**	**State**	**Zip**

Telephone Number

Specialists (name and phone)

MEDICAL HISTORY

FAMILY HISTORY

Check all that apply — Family member with disease

☐ Asthma ______________________________

☐ Tuberculosis ______________________________

☐ Diabetes ______________________________

☐ Heart Disease ______________________________

☐ Hypertension ______________________________

☐ Kidney Disease ______________________________

☐ Cancer, type ______________________________

☐ Rheumatologic Disease, type ______________________________

☐ Other, describe ______________________________

Updated 01/5/17

Icahn School of Medicine at Mount Sinai

Student Health Center

Mount Sinai
One Gustave L. Levy Place, Box 1260
New York, NY 10029-6574

Tel: (212) 241-6023
Fax: (212) 241-8008
studenthealth@mssm.edu

MEDICAL HISTORY, CONTINUED

PERSONAL HISTORY

(check all that apply)

- ☐ Sinus Infections
- ☐ Ear Infections
- ☐ Eye Problems
- ☐ Recurrent Colds
- ☐ Asthma
- ☐ Allergies
- ☐ Chronic Cough
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Tuberculosis or Positive PPD
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Gallbladder Disease
- ☐ Hepatitis
- ☐ Chronic Diarrhea
- ☐ Constipation
- ☐ Peptic Ulcer
- ☐ Celiac Disease
- ☐ Urinary Tract Infections
- ☐ Kidney Disease
- ☐ Head Injury
- ☐ Headaches
- ☐ Dizziness / Fainting
- ☐ Seizures
- ☐ Paralysis
- ☐ Hearing Problems
- ☐ Speech Problems
- ☐ Joint Pain
- ☐ Gout
- ☐ Back Pain
- ☐ Anemia
- ☐ Sickle Trait / Disease
- ☐ Thalassemia Trait / Disease
- ☐ Weight Gain / Loss
- ☐ Insomnia
- ☐ Anxiety
- ☐ Depression
- ☐ Irregular menses
- ☐ Severe Cramps
- ☐ Breast Mass
- ☐ Other: ____________________

ADDITIONAL INFORMATION

Please answer the following questions:

Has your education or work been interrupted due to a medical reason in the past two years? ________________________

____

Medications (include over-the-counter drugs, vitamins, alternative medicines, insulin and contraceptive) Specify dosage: ____

____

Hospitalizations and surgeries (include year and reason): ________________________________

____

Allergies (include medication, food and environmental allergens): ____________________________

____

Updated 01/5/17