



Cornell University

Please return this form to:
Cornell Health
110 Ho Plaza
Ithaca, NY 14853-3101

For information or assistance:
immunization@cornell.edu
607.255.4364

Visitor or Short-term Employee

Health History Form

Welcome to Cornell Health. Known as a primary care facility for the health needs of students, Cornell Health offers limited services for visitors and short-term employees at Cornell. Cornell Health is accredited by the Accreditation Association for Ambulatory Health Care. The information you provide here, as well as all health care provided at Cornell Health, is confidential. Cornell Health will not release any information about you without your written permission, except as authorized or required by law, or in our judgment as necessary to protect you or others from a serious threat to health or safety.

PART ONE: IDENTIFICATION AND PRIVACY

IDENTIFICATION

Status [] Visitor [] Other (describe) Name of Cornell Program

Name (last, first, middle) Date of Birth (mm-dd-yyyy) Gender

Cornell ID# or Net ID E-mail Address

Ithaca-area Address Street or P.O. Box

City State/Province Zip or Postal Code Country

Phone Numbers Ithaca Home Cell Work

Permanent Address (if different) Street or P.O. Box

City State/Province Zip or Postal Code Country

Phone Numbers Permanent Home Cell Work

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name Relationship

Phone Numbers Home Cell Work

PRIVACY INFORMATION Requires signatures of the patient, and the parent/guardian if an individual is under the age of 18.

Cornell Health has a long-standing commitment to the rights and privacy of its patients and clients. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all health care providers to inform patients/clients of their Notice of Privacy Practices. Please review the Notice of Privacy Practices at health.cornell.edu. It describes our policy and the ways in which we use and protect your personal health information.

I acknowledge that I have been given the opportunity to read Cornell Health's Notice of Privacy Practices via the website.

Signature(s) Patient Parent/guardian Date (mm-dd-yyyy)

I consent to have Cornell Health use and disclose my protected health information for payment, treatment, and health care operations purposes. My protected health information means health, billing, and demographic information about me, collected from me, and created or received by Cornell Health. In the event Cornell Health participates with my health insurance, I authorize the payment of benefits to Cornell Health.

Signature(s) Patient Parent/guardian Date (mm-dd-yyyy)

FOR PATIENTS UNDER AGE 18: PERMISSION TO TREAT & SHARE NECESSARY HEALTH INFORMATION

I give my permission for my daughter/son/ward to receive health care from Cornell Health, Five Star Urgent Care, Cayuga Medical Center (including Convenient Care) and, if necessary, ambulance services in the event of an injury or illness. I understand that I will be responsible for all charges for health services provided by Cornell Health and by off-campus providers.

Signature of parent/guardian Date (mm-dd-yyyy)

I understand that information about the immunizations my daughter/son/ward receives at Cornell Health will be shared with the New York State Immunization Information System (NYSIIS) as required by NY State Law. I have been made aware that information about this law is available at health.ny.gov/prevention/immunization/information_system/parents/.

Signature of parent/guardian Date (mm-dd-yyyy)

PART TWO: HEALTH HISTORY

PERSONAL HEALTH CARE PROVIDER

Name _____ (last, first, middle) _____ (degree/title) Work Phone _____

Address _____ Street or P.O. Box _____

City _____

State/Province _____

Zip or Postal Code _____

Country _____

PERSONAL HEALTH HISTORY

Check all you have had in the past or have at this time.

Alcohol, tobacco, and other drugs

- Alcohol use (#drinks/week ____)
- Tobacco use (#packs/week ____)
- Other drugs *(specify)

- Asthma
- Autoimmune disorder
- Autism spectrum disorder
- Blood disorders, anemia
- Cancer

Cardiovascular disease

- Heart problem
- High blood pressure
- High cholesterol
- Pacemaker
- Eating disorder
- Endocrine disorder**
- Diabetes
- Thyroid
- Other *(specify)

- Eye disease
- Vision deficit
- Gastrointestinal condition *(specify)
- Head injury/concussion
- Hearing impairment
- Hepatitis B (acute or chronic)
- Hepatitis C
- HIV
- Hospitalization *(specify)
- Kidney disease

- Menstrual disorders
- Mental health disorder *(specify)
- Migraine headaches
- Mobility limitations *(specify)
- Musculoskeletal problems**
- Fractures *(specify)
- Other *(specify)
- Neurologic concerns
- Seizure disorder
- Surgical operations or procedure(s) *(specify)

* Please provide a brief explanation regarding history above. List metal implants, prostheses, and special needs you have. _____

ALLERGIES

Drug allergies

- No known drug allergies
- Acetaminophen
- Amoxicillin
- Aspirin
- Lidocaine/Xylocaine
- Penicillin
- Sulfa drugs
- Other drug allergy (specify below)

Other allergies

- No known "other" allergies
- Animals
- Foods
- Insect/bee sting
- Latex
- Xray contrast
- Other allergy (specify below)

Please provide a brief explanation of all allergies you indicated above. Provide name/phone number of current allergist. _____

MEDICATIONS (frequent or regular)

- Acne medication
- ADHD medication
- Allergy medication
- Allergy shots
- Antidepressant medication
- Asthma medication
- Birth-control medication
- Blood pressure medication
- Bowel medication
- Headache medication
- Heart-rhythm medication
- Herbal treatments
- Insulin
- Pain medication
- Psychological condition medication
- Seizure medication
- Vitamins
- Other (specify below)

Please provide the name, dosage, and indication for the medications you marked above. _____

TETANUS

Booster type (TDaP, TD, or other tetanus) Date (mm-dd-yyyy) _____