EMPLOYEE FORMS

St. Bonaventure University
Center for Student Wellness
EMPLOYEE HEALTH FORMS

EMPLOYEE FORMS

NAME: Last _____ First _____ Middle_____

Previous names used (i.e. maiden names, etc):_____

HOME ADDRESS: Street _____ PO Box: _____ City: _____

State/Province:_____ Zip Code: _____ Country:_____

PHONE: Home_____ Cell _____ **EMAIL** _____

GENDER: Male Female Other (please specify): _____

DATE OF BIRTH: (MM/DD/YYYY) _____ EMPLOYEE ID: _____

FORMER SBU STUDENT? YES NO If yes, last semester/year attended: _____

***By filling out the emergency contact information, you are consenting to allow us to contact the person listed below in the event you are having a safety or life-threatening emergency.**

EMERGENCY CONTACT: _____RELATION TO EMPLOYEE: _____

PHONE: Home_____ Cell _____ Business _____

INSURANCE INFORMATION: **Do you have health insurance? _____ YES _____ NO**

Select one: _____ On parent/guardian/spouse policy _____ Individual policy holder

Insurance company name: _____

Toll-free number on card: _____

Policy holder's name (if not self): _____ Relationship to policy holder: _____

Policy holder's date of birth: _____

Policy number: _____ Group number: _____

ALLERGY INFORMATION: Are you allergic to any medications? Circle one: YES NO
If yes, please list here: _____

PRESCRIPTIONS

Are you taking any prescription medications on a regular basis? Circle One: YES NO

If yes, please list here noting dosage, frequency, and reason for taking: _____

_____

_____

IMMUNIZATION INFORMATION:

Are you up to date with your immunizations? (Circle one) YES NO UNSURE

Do you receive a flu shot regularly? (Circle one) YES (Date of last shot: _____) N

HEALTH HISTORY

Do you smoke? ☐ Yes ☐ Former smoker ☐ Never a smoke If yes, how much? _____

Do you have a history of any of the following: (explain any of the conditions checked in the space below).

☐ Allergies (I.e. foods, seasonal, pets, etc.)	☐ Genitourinary concerns
☐ Cancer Type:	☐ Head, eyes, ears, throat problems (i.e. migraines, sight/hearing deficiencies, etc.)
☐ Cardiac (Heart) issues	☐ Muscle/bone problems (i.e. arthritis, previous injuries)
☐ Clotting disorder	☐ Neurological conditions (i.e. history of strokes, seizures, etc.)
☐ Chronic pain issues (i.e. neuropathy, fibromyalgia)	☐ Respiratory disorders (i.e. asthma, chronic cough, COPD)
☐ Circulatory issues(i.e. blood disorders, high blood pressure)	☐ Other conditions, list here:
☐ Endocrine disorders (i.e. diabetes, thyroid conditions)	
☐ Gastrointestinal (digestive) problems (i.e. irritable bowel)	

Explain any checked items from the list above: _____

_____

_____

_____

PRIMARY CARE PROVIDER INFORMATION

Name of primary care provider: _____

Address: _____

Phone number: _____ Fax (if known): _____

Date of last office visit: _____

I attest that the information provided above is accurate and true to the best of my knowledge. Failure to provide accurate healthcare information to a provider may result in reduced quality of care, and the provider operating as an agent of St. Bonaventure University assumes no liability in the event that misinformation provided by the patient results in inappropriate recommendations or negative consequences.

Patient Signature: _____ Date/Time: _____

Staff witness: _____ Date/Time: _____