New Paltz
STATE UNIVERSITY OF NEW YORK
Student Health Service ▪ Division of Student Affairs
1 Hawk Drive ▪ New Paltz, NY 12561-2443 ▪ 845-257-3400 ▪ Fax 845-257-3415
healthservice@newpaltz.edu

INTERIM QUESTIONNAIRE

From: _____________ to Present

Name: ____________________________________ DOB: __________ Phone number: ______________

Address: ____

Please complete requested information below:

Have you been to a physician, hospital or clinic for a significant health issue since your last visit to the Student Health Services? ☐ Y ☐ N

Please update information below:

Any significant medical illness? ☐ Y ☐ N

Date: ____________ Provider: ____

Diagnosis: ____

Anxiety, depression or any psychological illness? ☐ Y ☐ N

Date: _____________ Provider: ____

Diagnosis: ____

Medication renewal? ☐ Y ☐ N

Date: ____________ Medication: ____

Checkup for chronic illness? ☐ Y ☐ N

Date: ____________ Provider: ____

Diagnosis: ____

Have you had any new medications prescribed? ☐ Y ☐ N

Date: ____________ Medication: ____

Have you been diagnosed with any new allergies to medications? ☐ Y ☐ N

Date: ____________ New Allergy: ____

Signature: ____ **Date**: ____________________