

**REPORT OF MEDICAL HISTORY**

(Please print in black ink)

To be completed by student

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN NAME PERSONAL ID#(PID) \*SOCIAL SECURITY NUMBER

PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

DATE OF BIRTH (mo/day/yr) GENDER  M  F MARITAL STATUS  S  M  OTHER EMAIL

CLASS YOU ARE ENTERING (circle): FR. SO. JR. SR. GRAD. PROF.	PREVIOUSLY ENROLLED HERE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATES _____	SEMESTER ENTERING (circle): FALL SPRING SUMMER 1 SUMMER 2 OTHER YEAR 20____
	PREVIOUSLY A PATIENT HERE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATES _____	

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY)		AREA CODE/TELEPHONE NUMBER
NAME OF POLICY HOLDER	*SOCIAL SECURITY NUMBER	EMPLOYER
POLICY OR CERTIFICATE NUMBER	GROUP NUMBER	IS THIS AN HMO/PPO/MANAGED CARE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. Please attach additional sheets for any items that require fuller explanation.

**FAMILY & PERSONAL HEALTH HISTORY** (Please print in black ink) To be completed by student

Has any person, related by blood, had any of the following:

	Yes	No	Relationship
High blood pressure			
Stroke			
Heart attack before age 55			
Blood or clotting disorder			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Relationship
Cancer (type):			
Alcohol/drug problems			
Psychiatric illness			
Suicide			

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year
High blood pressure			
Rheumatic fever			
Heart trouble			
Pain or pressure in chest			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Head or neck radiation treatments			
Tumor or cancer (specify)			
Malaria			
Thyroid trouble			
Diabetes			
Serious skin disease			
Mononucleosis			

	Yes	No	Year
Hay fever			
Allergy injection therapy			
Arthritis			
Concussion			
Frequent or severe headache			
Dizziness or fainting spells			
Severe head injury			
Paralysis			
Disabling depression			
Excessive worry or anxiety			
Ulcer (duodenal or stomach)			
Intestinal trouble			
Pilonidal cyst			
Frequent vomiting			
Gall bladder trouble or gallstones			

	Yes	No	Year
Jaundice or hepatitis			
Rectal disease			
Severe or recurrent abdominal pain			
Hernia			
Easy fatigability			
Anemia or Sickle Cell Anemia			
Eye trouble besides need glasses			
Bone, joint, or other deformity			
Knee problems			
Recurrent back pain			
Neck injury			
Back injury			
Broken bone (specify)			
Kidney infection			
Bladder infection			

	Yes	No	Year
Kidney stones			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Severe menstrual cramps			
Irregular periods			
Sexually transmitted			
Blood transfusion			
Alcohol use			
Drug use			
Anorexia/Bulimia			
Smoke 1+ pack cigarettes/week			
Regularly exercise			
Wear seat belt			
Other (specify)			

Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_ Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_

Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_ Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_

Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_ Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_

Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_ Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_

\* Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.

**FAMILY & PERSONAL HEALTH HISTORY-CONTINUED** (Please print in black ink) To be completed by student

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet). Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions to:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine			
Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and why)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there loss or seriously impaired function of any paired organs? (Please describe)			
Other than for routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)			

**IMPORTANT INFORMATION....PLEASE READ AND COMPLETE**

**STATEMENT BY STUDENT (OR PARENT /GUARDIAN, IF STUDENT UNDER AGE 18):**

- (A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.
- (B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians of the Student Health Service. **(Not applicable to community colleges.)**
- (C) I am aware that the Student Health Service charges for some services and I may be billed through the University Cashier if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage. **(Not applicable to community colleges.)**

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian, if student under age 18

\_\_\_\_\_  
Date

**PHYSICAL EXAMINATION**  
or clinic

(Please print in black ink) To be completed and signed by physician

A physical examination is required by **some schools and/or programs** (consult your college or department for specific requirements). **Required** - completed in black ink and signed by a physician or clinic.

Last Name	First Name	Middle Name	Date of Birth (mo/day/year)	*Social Security Number

Permanent Address	City	State	Zip Code	Area Code/Phone Number	

Height \_\_\_\_\_ Weight \_\_\_\_\_ TPR \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_

<b>REQUIRED:</b> <u>Vision:</u> Corrected Right 20/ _____ Left 20/ _____ Uncorrected Right 20/ _____ Left 20/ _____ Color Vision _____ <u>Hearing:</u> (gross) Right _____ Left _____ 15 ft. Right _____ Left _____	<b>REQUIRED:</b> <u>Urinalysis:</u> Sugar: _____ Albumin _____ Micro _____ <u>Hgb or Hct</u> _____
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Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

- A. Is there loss or seriously impaired function of any paired organs? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Explain \_\_\_\_\_
- B. Is student under treatment for any medical or emotional condition? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Explain \_\_\_\_\_
- C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited \_\_\_\_\_ Limited \_\_\_\_\_  
 Explain \_\_\_\_\_
- D. Is student physically and emotionally healthy? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Explain \_\_\_\_\_

<b>• REQUIRED •</b>	
Based on my assessment of this student's physical and emotional health on _____, he/she appears able to participate in the activities of a health profession in a clinical setting. Yes _____ No _____ if no, please explain _____	

\_\_\_\_\_  
Signature of Physician/Physician Assistant/Nurse Practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Physician/Physician Assistant/Nurse Practitioner

\_\_\_\_\_  
Area Code/Phone Number

\_\_\_\_\_  
Office Address City State Zip Code

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