



MEDICAL HISTORY

please print/type

Last Name		First Name		Middle Name		ID#/SSN#	
Date of Birth (MM/DD/YY)		Sex/Gender		Country of Birth		Cell #	
Permanent Address		City		State		Zip Code	
Local Address		City		State		Zip Code	
Check One:		<input type="checkbox"/> African American (2)		<input type="checkbox"/> East Indian		<input type="checkbox"/> Other _____	
		<input type="checkbox"/> Asian or Pacific Islander (3)		<input type="checkbox"/> Hispanic (4)			
		<input type="checkbox"/> Caucasian (6)		<input type="checkbox"/> Native American/Alaskan Native (1)			

In Case of Emergency, Notify:

Name		Relationship		Phone #	
Address		City		State	
				Zip Code	

Drug/Medication Allergies: (write NONE if none)	Other Allergies: (write NONE if none)	Routine Medications Taken: (write NONE if none)
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HAVE YOU HAD:	YES	NO	YES	NO	YES	NO
Asthma			Hepatitis A, B, or C		Visual Problem (other than glasses)	
Bleeding/Blood Disorder			High Blood Pressure		Alcohol Use: # times per week: _____ amount per session: _____	
Cancer/Tumor/Cyst			High Cholesterol		Recreational Drug Use	
Chicken Pox			Kidney/Urinary Tract Problem		Tobacco Use	
Counseling/Mental Health Treatment			Malaria		Exercise: # time per week	
Diabetes			Recent Weight Change		Operations / Dates:	
Digestive Tract Problems			Recurrent Ear Infections			
Eating Disorder			Recurrent Headaches			
Gynecology Problem(s)			Rheumatic Fever			
Hay Fever			Scarlet Fever			
Head Injury with Unconsciousness			Seizure Disorder			
Hearing Loss			Sexually Transmitted Disease			
Heart Problem/Murmur			Spinal Cord Disruption			
Other Infectious or chronic Health Problems? If so, what?			Thyroid Problem			
			Tuberculosis			
						Alternative Medicine Practices: (Accupuncture, Herbal Supplements, etc.)

Family Member	Occupation	Health Status Excellent/Average/Poor	Age	If no longer living, Cause of Death & Age at Death
Father				
Mother				
Brothers				
Sisters				
Spouse/Partner				
Children				

HAS ANY FAMILY MEMBER EVER HAD:

(parent, sibling, or grandparent)

YES NO Relationship

YES NO Relationship

Arthritis				Kidney Disease			
Asthma				Obesity			
Blood Disorder				Seizure Disease			
Cancer				Stomach Disease			
Diabetes				Stroke			
Drug/Alcohol Abuse				Thyroid Disease			
Heart Disease				Tuberculosis			
High Blood Pressure				Other			
High Cholesterol							

YES NO

Have you had a tuberculin (TB) skin test in the past 12 months?			Results?	Date:
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YES NO

YES NO

YES NO

Insurance on file at UIS?			PPO			HMO		
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Insurance Company: _____
Policy Number: _____

Other Concerns/Information:

If you have the Student Insurance, please check with the Department of Human Resources (206-6652) to determine what your coverage is for lab tests, x-rays, referrals to specialists, etc., which are ordered by our staff. **If you have private insurance**, please let us know if your policy has any limitations as to where lab tests, x-rays, referrals to specialists, etc. must be made. All medical bills are **your** responsibility.

Address and Medical History Reviewed
(office Use Only)

Student Signature _____ Date: mm/dd/yy
Parent Signature _____ Date: mm/dd/yy
(if Student is under 18 years old)