UNIVERSITY HEALTH SERVICES

Stephen F. Austin State University, Nacogdoches,Texas 75962

Medical History: CID_______________ **Date:**___/____/____

Name:_______________________________
Last (Print), First, Middle

Home Address:____ City: ___________________________ State: __________ Zip:_______

Name, Relationship of Next of Kin:____Phone: (_____)________________

Next of Kin's Home Address:____

Next of Kin's Business Address:____ Phone No. (_____)______________

The information you provide is strictly for the use of the Health Service at Stephen F. Austin State University, and will not be released to anyone without your knowledge and consent. This information is used solely as an aid in providing you with necessary health care.

Family History: Please indicate each family member's current state of health, and history and if a member died.

	Father	Mother	Brother(s)	Sister(s)	Spouse	Children
Age (yrs.)						
State of Health (good, poor, deceased)						
If dead, cause of death						
Occupation						
Asthma/Hayfever						
Arthritis						
Cancer (type)						
Diabetes						
Epilepsy						
Heart Trouble						
High Blood Pressure						
Kidney Disease						
Psychiatric						
Peptic Ulcers						
Thyroid Disorders						
Other						

Personal Health History: Mark an X in the box next to any of the following illnesses you now or have ever had.

[] Measles	[] More than 2 ear, nose or throat infections each year	[] Chronic indigestion or stomach problem	[] Hemorrhoids
[] German measles	[] High blood pressure	[] Weight loss or difficulty	[] Psychiatric History
[] Infectious mononucleosis (mono)	[] Low blood pressure	maintaining weight	[] Migraine or frequent headaches
[] Chickenpox	[] Diabetes	[] Joint disease/arthritis	[] Neuralgia
[] Mumps	[] Thyroid disorder	[] Kidney or urinary tract trouble	[] Pancreas or liver disease
[] Sexually transmitted disease	[] Low blood sugar	[] Muscle weakness or paralysis	
[] Rheumatic fever	[] Eczema or chronic skin rashes	[] Impaired vision/glasses or contacts	**Women Only** [] Irregular menstruation
[] Tuberculosis or a positive	[] Hives	[] Hernia	[] Severe menstrual cramping
tuberculin skin reaction	[] Asthma/Hayfever		[] Excessive menstrual bleeding

List Previous Hospitalizations and Surgery with Dates:____

List current medications you take:

____

____

List medical conditions for which you have been treated:

____

____

List any Medications you cannot take because of Allergy or other reason:____