Hispanic Ethnicity: Yes ◯ No ◯

Race: ***check all that apply***
W ◯ B ◯ AIS ◯ AI ◯ PI ◯

UNIVERSITY STUDENT HEALTH SERVICES
Stephen F. Austin State University, Nacogdoches, Texas 75962

Gender:
Male ◯
Female ◯

Medical History: Name:_____(STICKER)_____ Today's Date: _____

SFASU Address: _____ City: _____ State: _____ Zip: _____

Personal Cell Phone Number: _____

Emergency Contact Person: _____
(Name/ Address/Telephone #) (Print Name)

Phone #: _____ Cell Phone #: _____

The information you provide is strictly for the use of Health Services 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 state of health and history:

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

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

◯ Measles	◯ Ear, nose and throat infection (more than 2 per year)	◯ Hives	◯ Neuralgia
◯ German Measles	◯ High blood pressure	◯ Weight loss or difficulty maintaining weight	◯ ADD/ADHD
◯ Mumps	◯ Low blood pressure	◯ Joint disease/arthritis	◯ Depression
◯ Chickenpox	◯ Thyroid disorder	◯ Kidney or urinary tract trouble	◯ Psychiatric history
◯ Infectious mononucleosis (mono)	◯ Low blood sugar	◯ Muscle weakness or paralysis	◯ Migraine or frequent headaches
◯ Sexually transmitted disease	◯ Eczema or chronic skin rashes	◯ Impaired vision	◯ Pancreas or liver disease
◯ Rheumatic fever	◯ Chronic indigestion or stomach problem	◯ Hernia	**Women Only:**
◯ Asthma/hayfever		◯ Hemorrhoids	◯ Irregular menstruation
◯ Tuberculosis or a positive tuberculin skin reaction			◯ Severe menstrual cramping
			◯ Excessive menstrual bleeding

List medical conditions for which you have been treated:

_____

_____

List current medications you take:

_____

_____

List Previous Hospitalizations and Surgery with Dates: _____

List any Medications you CANNOT take because of Allergy or other Reasons: _____