

Hispanic Ethnicity: Yes No

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

Gender:
 Male
 Female

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

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.

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