STEPHEN F. AUSTIN STATE UNIVERSITY
Health and Wellness Hub

Gender: Male ○ Female ○

Hispanic Ethnicity: Yes ○ No ○
Race: check all that apply
W ○ B ○ AIS ○ AI ○ PI ○

Medical History Form

Date: ___________________

Name: ____ Date of Birth: ____________________

SFASU Address: ______________________________ City: ___________________ State: _____ Zip: ___________

Phone #: ____________________________________ Cell Phone #: ______________________________________

Emergency Contact Person (Print Name): ____

Emergency Contact Phone Number: ____

The information you provide is strictly for the use of Health Services at Stephen F. Austin State University, and it 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						
State of Health (good, poor, deceased)						
If deceased, cause of death						
Occupation						
Blood Diseases						
Cancer						
Diabetes						
Seizure Disorder						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Respiratory Disease						

Personal History- Please answer all questions

○ ADD/ADHD	○ Eye Trouble	○ Sickle Cell Disease
○ Anemia	○ Head Injury or Concussion	○ Sleep Disorders
○ Asthma	○ Heart Problems	○ Stomach or Intestinal Trouble
○ Blood/Clotting Disorder	○ High Blood Pressure	○ Thyroid Disease
○ Bone/Joint Problems	○ Kidney Disease	○ Tuberculosis
○ Cancer/Tumor	○ Mental Health Problems	Women Health ○ Irregular menstruation ○ Severe menstrual cramping ○ Excessive menstrual bleeding
○ Diabetes	○ Migraines	
○ Ear Trouble	○ Seizures	

List medical conditions for which you have been treated: ____

____

List all current medications (including supplements and vitamins): ________________________________

____

List all hospitalizations/Surgeries with dates: ____

____

Allergies (list any medications and food you are allergic to): ____________________________________

____