T#____________________

TENNESSEE STATE UNIVERSITY

STUDENT HEALTH SERVICES

MEDICAL HISTORY QUESTIONNAIRE

PLEASE PRINT CLEARLY.

NAME ____

Last First Middle

LAST 4 DIGITS OF SSN _________ BIRTHDATE _______________ AGE __________

PERMANENT ADDRESS ____

CITY____________________________ STATE _______________ ZIP CODE____________

HOME PHONE (______) _______________ CELL PHONE (_____) ________________

E-MAIL ADDRESS ____

DO YOU HAVE HEALTH INSURANCE? __________

IF SO, COMPANY AND POLICY#. ____

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? Please Circle.

Asthma Hypertension Rheumatic Fever

Diabetes Migraine Headaches Seizure Disorders

Heart Disease Peptic Ulcers Tuberculosis

OTHER SERIOUS MEDICAL CONDITION(S)

____

HAVE YOU EVER BEEN TREATED FOR A NERVOUS OR EMOTIONAL CONDITION?

____

IF SO, PLEASE EXPLAIN. ____

____

LIST ANY MEDICATIONS THAT YOU TAKE REGULARLY.

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

LIST ANY MEDICATIONS TO WHICH YOU ARE ALLERGIC.

_________________________ _________________________ _________________________

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

NAME ____ RELATIONSHIP _______________

CONTACT NUMBER(S) ____

If a student is under 18 years of age, we need permission to treat the student/hospitalize for a serious illness at the discretion of the Student Health Center physician. Parent, please sign, if applicable.

Parent or (Guardian) _____________________________________ **Date** __________

SIGNATURE OF STUDENT _____________________________________ **Date**___________