***REPORT OF MEDICAL HISTORY****(Please print in black ink)To be completed by student*

LAST NAME (print) FIRST NAME MIDDLE NAME FSU Student ID Number \*SOCIAL SECURITY NUMBER

PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER



DATE OF BIRTH (mo/day/yr) GENDER M F MARITAL STATUS S M OTHER EMAIL

 CLASS YOU ARE ENTERING (circle):

FR. SO. JR. SR. GRAD. PROF.

SEMESTER ENTERING (circle): FALL SPRING

SUMMER 1 SUMMER 2 OTHER YEAR 20







 PREVIOUSLY ENROLLED HERE YES NO

 IF YES, DATES





 PREVIOUSLY ENROLLED HERE YES NO

 IF YES, DATES

 HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) AREA CODE/TELEPHONE NUMBER

 NAME OF POLICY HOLDER \*SOCIAL SECURITY NUMBER EMPLOYER

 IS THIS AN HMO/PPO/MANAGED CARE PLAN? YES NO

 POLICY OR CERTIFICATE NUMBER GROUP NUMBER







NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

 The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. *Please attach additional sheets for any items that require fuller explanation.*

***FAMILY & PERSONAL HEALTH HISTORY****(Please print in black ink)To be completed by student*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Relationship |
| Cancer (type): |  |  |  |
| Alcohol/drug problems |  |  |  |
| Psychiatric illness |  |  |  |
| Suicide |  |  |  |

 Has any person, related by blood, had any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Relationship |
| High blood pressure |  |  |  |
| Stroke |  |  |  |
| Heart attack before age 55 |  |  |  |
| Blood or clotting disorder |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Relationship |
| Cholesterol or blood fat disorder |  |  |  |
| Diabetes |  |  |  |
| Glaucoma |  |  |  |
|  |  |  |  |

 HEIGHT WEIGHT

 Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Year |
| High blood pressure |  |  |  |
| Rheumatic fever |  |  |  |
| Heart trouble |  |  |  |
| Pain or pressure inchest |  |  |  |
| Shortness of breath |  |  |  |
| Asthma |  |  |  |
| Pneumonia |  |  |  |
| Chronic cough |  |  |  |
| Head or neck radiation treatments |  |  |  |
| Tumor or cancer(specify) |  |  |  |
| Malaria |  |  |  |
| Thyroid trouble |  |  |  |
| Diabetes |  |  |  |
| Serious skin disease |  |  |  |
| Mononucleosis |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Year |
| Hay fever |  |  |  |
| Allergy injection therapy |  |  |  |
| Arthritis |  |  |  |
| Concussion |  |  |  |
| Frequent or severe headache |  |  |  |
| Dizziness or fainting spells |  |  |  |
| Severe head injury |  |  |  |
| Paralysis |  |  |  |
| Disabling depression |  |  |  |
| Excessive worry or anxiety |  |  |  |
| Ulcer (duodenal or stomach) |  |  |  |
| Intestinal trouble |  |  |  |
| Pilonidal cyst |  |  |  |
| Frequent vomiting |  |  |  |
| Gall bladder trouble or gallstones |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Year |
| Jaundice or hepatitis |  |  |  |
| Rectal disease |  |  |  |
| Severe or recurrent abdominal pain |  |  |  |
| Hernia |  |  |  |
| Easy fatigability |  |  |  |
| Anemia or Sickle Cell Anemia |  |  |  |
| Eye trouble besides need glasses |  |  |  |
| Bone, joint, or other deformity |  |  |  |
| Knee problems |  |  |  |
| Recurrent back pain |  |  |  |
| Neck injury |  |  |  |
| Back injury |  |  |  |
| Broken bone(specify) |  |  |  |
| Kidney infection |  |  |  |
| Bladder infection |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Year |
| Kidney stones |  |  |  |
| Protein or blood in urine |  |  |  |
| Hearing loss |  |  |  |
| Sinusitis |  |  |  |
| Severe menstrual crampssever |  |  |  |
| Irregular periods |  |  |  |
| Sexually transmitted disease |  |  |  |
| Blood transfusion |  |  |  |
| Alcohol use |  |  |  |
| Drug use |  |  |  |
| Anorexia/Bulimia |  |  |  |
| Smoke 1+ pack cigarettes/week |  |  |  |
| Regularly exercise |  |  |  |
| Wear seat belt |  |  |  |
| Other (specify) |  |  |  |

 Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

 Name Use Dosage Name Use Dosage

 Name Use Dosage Name Use Dosage

 Name Use Dosage Name Use Dosage

 Name Use Dosage Name Use Dosage

 \* Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.

**Page 3**

***FAMILY & PERSONAL HEALTH HISTORY-CONTINUED****(Please print in black ink)To be completed by student*

 Check each item “Yes” or “No.” Every item checked “Yes” must be fully explained in the space on the right (or on an attached sheet).

 Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

|  |  |  |  |
| --- | --- | --- | --- |
| **Adverse Reactions to:**  | Yes | No | Explanation |
| Penicillin |  |  |  |
| Sulfa |  |  |  |
| Other antibiotics (name) |  |  |  |
| Aspirin |  |  |  |
| CodeineOther pain relievers |  |  |  |
| Other drugs, medicines, chemicals (specify) |  |  |  |
| Insect bites |  |  |  |
| Food allergies (name) |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Explanation |
| Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe) |  |  |  |
| Have you ever been a patient in any type of hospital? (Specify when, where, and why) |  |  |  |
| Has your academic career been interrupted due to physical or emotional problems? (Please explain) |  |  |  |
| Is there loss or seriously impaired function of any paired organs? (Please describe) |  |  |  |
| Other than for routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe) |  |  |  |
| Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details) |  |  |  |

**IMPORTANT INFORMATION….PLEASE READ AND COMPLETE**

 **STATEMENT BY STUDENT (OR PARENT /GUARDIAN, IF STUDENT UNDER AGE 18):**

1. I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter’s) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.
2. I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians of the Student Health Service. (Not applicable to community colleges.)
3. I am aware that the Student Health Service charges for some services and I may be billed through the University Cashier if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage. (Not applicable to community colleges.)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student Name (print) FSU Student ID Number**

**Signature of Student Date**

**Signature of Parent/Guardian, if student under age 18 Date**

Page 4