

GENERAL INFORMATION

Name _____ Birth Date ____/____/____

Home Address _____ Phone Number (____) _____
Number & Street, P.O. Box or Apt. # City State Zip

Gender: ___Male ___Female T# _____ Marital Status: ___S ___M ___D ___W

Emergency Contact Information: Name _____ Phone Number (____) _____

Family Physician: Name _____ Phone Number (____) _____

PAST MEDICAL HISTORY

Have you had any of the following conditions or related conditions? If "yes," please describe. List the frequency and severity, medications or surgeries.

___ Yes ___ No | Respiratory System: hay fever, asthma, tuberculosis, sinus problems? _____

___ Yes ___ No | Cardiovascular: palpitations, high/low blood pressure, chest pain, heart murmur, heart disease? _____

___ Yes ___ No | Blood Diseases Disorders: anemia, bleeding tendencies? _____

___ Yes ___ No | Muscle-Skeletal: "trick" knee, back problems, broken bones, recurrent sprains/tendonitis, deformities, arthritis? _____

___ Yes ___ No | Endocrine: thyroid, diabetes, adrenal? _____

___ Yes ___ No | Gastro-intestinal: ulcer, gallbladder, diarrhea, constipation? _____

___ Yes ___ No | Genitourinary: menstrual problem, kidney/bladder problems, prostatitis, vaginal infections? _____

___ Yes ___ No | Neurological: seizures, hearing problems, head injury with unconsciousness? _____

___ Yes ___ No | Psychological: anxiety, depression, other emotional disorders? _____

___ Yes ___ No | Infections: rheumatic fever, malaria, hepatitis? _____

___ Yes ___ No | Surgeries: tonsillectomy, appendectomy, hernia repair, other? _____

___ Yes ___ No | Tumor/cyst/cancer? _____

CURRENT MEDICAL HISTORY

___ Yes ___ No | Allergies: medicines, bee stings, other? If "yes," please list: _____

___ Yes ___ No | Are you currently taking any prescribed drugs or medical treatment (including birth control pills)?

___ Yes ___ No | Do you know any reasons why you should not participate in normal physical exercise?

___ Yes ___ No | Do you have any questions regarding your health or other matters you'd like to discuss with the Health Services Staff?

IMMUNIZATION REQUIRED (Requires signature or stamp from health care provider below or official document attached)

Vaccines	Dates	Signature
MMR (measles, mumps, rubella)	1. _____ 2. _____	_____
Varicella (chicken pox)	1. _____ 2. _____	_____

Or documentation of disease by medical personnel. _____

IMMUNIZATIONS RECOMMENDED (Requires signature or stamp from health care provider below or official document attached)

Tetanus (within past 10 years)	_____	_____
Meningitis	_____	_____
Hepatitis B	_____	_____
	_____	_____
	_____	_____
TB Skin Test	Date given: _____	_____

PERMISSION FOR TREATMENT AT TTU STUDENT HEALTH SERVICES

(If under 18, co-signed by parent or guardian)

Student signature	_____	Date	_____	Parent or guardian signature	_____	Date	_____
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