Tennessee Tech University

Student Health Form

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.

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? Yes No ______________________________

CURRENT MEDICAL HISTORY

Allergies: medicines, bee stings, other? Yes No If "yes," please list: ______________________________

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? Yes No

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

Vaccines	Dates	Signature
Proof of two required	1.____________________	______________________________
MMR (measles, mumps, rubella)	2.____________________	______________________________

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*

Please return to Tennessee Tech University, Student Health Services, Box 5096, Cookeville, TN 38505-0001.

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