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.

____ 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

Please return to Tennessee Tech University, Student Health Services, Box 5096, Cookeville, TN 38505-0001, or fax to (931) 372-3848.