KENT STATE UNIVERSITY | University Health Services

Medical History Form

This form will become a part of your Medical Record and will be treated as per our Privacy Notice.

******If you are under 18 years old, please see receptionist before completing form******

PLEASE PRINT

_____/_____/_____ _____/_____

Legal Name: Last First MI KSU ID # Date of Birth

_____ (_____)_____-_____ _____

Preferred Name Cell Phone# Country of Origin

Primary Person to Notify in Case of an Emergency

Name _____Relationship _____

Home Phone _____Business Phone _____Cell Phone _____

ALLERGIES: Have you ever had an allergic reaction? ☐ YES ☐ NO If yes, please list allergies and describe the reaction(s):

_____

_____

MEDICATIONS: Please list all medications currently being taken with dosage, frequency, and condition for which it is being taken. Please include birth control and all over-the-counter medications. If you are not taking any medications, please check none. ☐ NONE

Medications	Dosage	Frequency	Diagnosis/Condition

YOUR MEDICAL HISTORY: ☐ NONE Have you ever had the following? Please circle all that apply:

Abuse
ADD/ADHD
Anemia
Anxiety
Arthritis
Asthma/Lung Disease
Blood Disorder/Clots
Breast Disorder
Cancer (specify type)
_____
Childbirth / Abortion / Miscarriage
Cholesterol Disorder
Depression
Diabetes
Eating Disorder
Gynecological Disorder (Ovarian Cysts, Endometriosis, Menopause, Other)
Head Injury / Concussion
Heart Disease / Heart Murmur
Hepatitis / Liver Problems
Kidney Disorder
Low/High Blood Pressure
Migraines / Headaches
Mono
Musculoskeletal / Back Problems
Recurrent UTIs
Seizures
Skin Disorder
Stomach / Digestive Disorder (Celiac, Crohns, IBS, Reflux, Other)
Thyroid Disorder
Tuberculosis (TB)

Other / Additional Information_____

PLEASE TURN OVER AND COMPLETE BACK OF FORM

Have you had any surgeries or hospitalizations? (For example, broken bones or removal of tonsils, appendix, adenoids, wisdom teeth, gallbladder, etc.) If yes, please list type and date. ☐ Yes ☐ No

_____

Do you have any disabilities or impairments? If yes, please explain. ☐ Yes ☐ No _____

Social History

Alcohol Use: Amount/Frequency _____ ☐ Never ☐ Quit: Date: _____

Tobacco Use: Currently smoke _____Cigarettes per day ☐ Never ☐ Quit: Date: _____

Recreational Drug Use: Type/Frequency _____ ☐ Never ☐ Quit: Date: _____

Family Medical History

☐Adopted, no history known ☐Adopted, history known (PLEASE FILL IN BELOW)

If any of your immediate family had/have the following check the box indicating which family member it applies to:

		Father	Mother	Sibling	Grandparent		Father	Mother	Sibling	Grandparent
Alcohol Dependency						Heart Disease				
Blood Clots						High Blood Pressure				
Cancer	Breast					Kidney Disease				
	Colon					Psychological Illness (Anxiety/Depression /Bipolar/Other)				
	Skin (Melanoma)									
	Other: _____									
Deceased						Stroke				
Diabetes						Thyroid Disorder				
Drug Dependency						Tuberculosis (TB)				
Elevated Cholesterol						Other _____				

If you do not have any family history of the above conditions, please check none. ☐ **NONE**

Medical Restrictions/Advance Directive

Do you have any medical restrictions associated with religious practices? ☐**YES** ☐**NO**
If yes, please explain:

_____

Do you have a living will / advance directive (a written statement of a person's wishes regarding medical treatment in circumstances in which they are no longer able to express informed consent)? ☐**YES** ☐**NO**

Would you like information about advance directives? ☐**YES** ☐**NO**

Patient Signature: _____ **Today's Date:** _____

Print Patient Name: _____ **Birthdate:** _____

Revised: 7/17 DKR