Kent State University Health Services

Medical History Form

1. This form must be returned to the Student Health Service prior to being seen at UHS.
2. This form will become a part of the Student Medical Record and will be treated as per our Privacy Notice.

_ ****If you are under 18 years old, please see receptionist before filling out form****

PLEASE PRINT

_____/_____/_____ _____/_____

Name: Last First MI Banner ID # /SSN# Date of Birth

Gender: _____ Country of Origin_____

_____

Local Address: Street City State Zip code Local Phone#

_____

Home Address: Street City State Zip code Home Phone #

_____ _____

Cell Phone# E-Mail Address

Primary Person to Notify in Case of an Emergency (Parent/Guardian)

Name _____Relationship _____

Home Phone _____Business Phone _____Cell Phone _____

ALLERGIES:

☐ NONE **Medications/Serums/other substances: Please List**

_____

Your Medical History:

☐ NONE **Check Mark all that apply and *explain below**

☐ Anxiety	☐ Diabetes	☐ Hepatitis/Liver Problems	☐ Thyroid Disorder	☐ Arthritis
☐ Asthma/Lung Disease	☐ Eating Disorder	☐ Cholesterol Disorder	☐ Anemia	Other_____
☐ Blood Disorder/Clots	☐ Seasonal Allergies	☐ Low/High Blood Pressure	☐ Abuse	
☐ Breast Disorder	☐ Stomach/Digestive Disorder	☐ Kidney Disorder	☐ Psychological Disorder	
☐ Cancer (specify type) _____	☐ Gynecological Disorder	☐ Mono	☐ Seizures	
☐ Head Injury	☐ Migraines	☐ Musculoskeletal/Back	☐ Childbirth	
☐ Depression	☐ Heart Disease/ Heart Murmur	☐ Skin Disorder	☐ Vision/Hearing Problems	

*Additional Information_____

Disability **(Specify Type):** ☐ None_____

Have you felt depressed or suicidal in the last 12 months? YES NO If yes, list any counseling, medications and/or hospitalizations: _____

Please list any surgeries and hospitalizations/_____ ☐None

PLEASE TURN OVER AND COMPLETE BACK OF FORM

MEDICATIONS ☐ **NONE** (List all medications currently being taken with dosage, frequency and condition for which it is being taken)

Medications	Dosage	Frequency	Diagnosis

Social History

Alcohol Use:	Amount/Frequency _____	☐ Never ☐ Quit
Tobacco Use:	Currently smoke _____Cigarettes/day	☐Never ☐ Quit
Drug Use:	Type/Frequency _____	☐ Never ☐ Quit

Family Medical History

☐ **NONE**

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/Drug Addiction					High Blood Pressure				
Blood Clots					Psychological Illness				
Cancer _____					Kidney Disease				
Diabetes					Stroke				
Heart Disease					Thyroid Disorder				
Elevated Cholesterol									

☐Adopted, no history known ☐Adopted, history known _____

Medical Restrictions/Advance Directive

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

Do you have a living will (advance directive)? ☐YES ☐NO

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

Consent, Release and Fee Responsibility Disclosure

I consent to the examinations, tests, and treatments which may be done by my clinician(s) and health center staff during my visits. I understand I have the right to discuss and ask questions about my treatment.

In case of emergency, I authorize the Director of Health Services or the medical staff to notify the parent or guardian named on this form if I am unable to do so. In that event, I further authorize the medical staff to make referrals for hospitalization and to release pertinent medical information necessary for my care.

I authorize University Health Services to use this form as consent for release of medical information to consulting/referring specialists and insurance carriers for claim payment purposes.

I understand that all fees incurred for services at University Health Services are my responsibility. University Health Services will bill most major medical plans provided that accurate information is provided by patients within 48 hours of their visit to the Health Center. Kent State University also sponsors a student insurance plan which is recommended for all students without adequate insurance coverage. Charges for non-covered services are the responsibility of the patient and will be billed to students' bursar accounts. Patients without insurance coverage are eligible to utilize the self pay fee schedule. An itemized accounting statement is available by request to all patients visiting the Health Center.

I understand the contents of the above statements, and my signature is a voluntary act. This authorization shall remain in effect until revoked in writing. A photocopy of this authorization shall be deemed as valid as the original

_____ _____

Printed Name Date

_____ _____

Signature of Student Date

_____ _____

2nd **(Reviewed History)** Initials Date

_____ _____

3rd **(Reviewed History)** Initials Date

_____ _____

4th **(Reviewed History)** Initials Date

_____ _____

5th **(Reviewed History)** Initials Date

_____ _____

Signature of parent/ guardian (If student is under 18 years of age) Date

Revised 9/10cp