

HEALTH HISTORY FORM

Missouri Western State University

Esry Student Health Center
4525 Downs Drive – Blum 203
St Joseph, MO 64507-9987
(816) 271-4495 • Fax (816) 271-4498

OFFICE USE ONLY

____ TB Test **NOT** required
____ TB Test **required**
____ Chest X-Ray required

SEMESTER YOU PLAN TO ATTEND: Fall _____ Spring _____ Summer _____ Today's Date _____

HAVE YOU PREVIOUSLY USED ESRY STUDENT HEALTH CENTER SERVICES? ___ NO ___ YES G-Number _____

Last Name _____ First Name _____ MI _____ Date of Birth _____ Age _____ M or F (Circle one)

Address _____ City _____ State _____ Zip _____
(_____) _____ (_____) _____
Phone _____ Cell Phone _____

Country of birth _____ Current E-Mail _____

Do you plan to live on campus? YES NO Participate in MWSU athletics? NO YES Which sport? _____

▶ HEALTH INSURANCE INFORMATION (Circle one)

Parent's Insurance Medicare Medicaid MWSU Student Health Insurance None

▶ EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
(_____) _____ (_____) _____ (_____) _____
Home Phone _____ Work Phone _____ Cell Phone _____
Primary Physician _____ Address _____ Phone _____ Fax _____

▶ ALLERGY HISTORY

List any drug allergies: _____ Reaction: _____
List any allergies to materials (such as latex) _____ Reaction: _____
List any food allergies: _____ Reaction: _____
List any allergies to insect bites: _____ Reaction: _____
Are you receiving allergy injections? ** _____ Reaction: _____

****NOTE:** If Esry Student Health Center is to administer your allergy vaccine, detailed instructions are required from your physician. Please contact the Health Center, 816-217-4495, for a packet of information to take to your allergist.

▶ CURRENT MEDICATIONS List any drugs, medications, birth control, vitamins, and dietary supplements you currently use:

▶ HOSPITALIZATION/SURGICAL HISTORY List any hospitalization and prior operations you have had, with dates (i.e. appendectomy, fracture):

▶ MENTAL HEALTH HISTORY Have you ever suffered from, been treated for, or hospitalized for the following?

Y	N		EXPLANATION
<input type="radio"/>	<input type="radio"/>	Bipolar disorder	
<input type="radio"/>	<input type="radio"/>	Substance abuse (alcohol, drugs)	
<input type="radio"/>	<input type="radio"/>	Eating disorder (anorexia, bulimia)	
<input type="radio"/>	<input type="radio"/>	Depression, anxiety	

▶ PERSONAL HISTORY Indicate whether you have had any of the following medical issues

Y	N	Have you had?	Y	N	Have you had?	Y	N	Have you had?
<input type="radio"/>	<input type="radio"/>	Acne	<input type="radio"/>	<input type="radio"/>	Hearing loss	<input type="radio"/>	<input type="radio"/>	Ulcers
<input type="radio"/>	<input type="radio"/>	Anemia/Sickle cell/Other	<input type="radio"/>	<input type="radio"/>	Heart murmur/other heart problems	<input type="radio"/>	<input type="radio"/>	Other: _____
<input type="radio"/>	<input type="radio"/>	Asthma/Lung disease	<input type="radio"/>	<input type="radio"/>	Hepatitis	FEMALES ONLY		
<input type="radio"/>	<input type="radio"/>	Bleeding problem	<input type="radio"/>	<input type="radio"/>	High blood pressure	<input type="radio"/>	<input type="radio"/>	Irregular periods
<input type="radio"/>	<input type="radio"/>	Blood clots in legs or lungs	<input type="radio"/>	<input type="radio"/>	High cholesterol	<input type="radio"/>	<input type="radio"/>	Breast lump or cyst
<input type="radio"/>	<input type="radio"/>	Broken bones	<input type="radio"/>	<input type="radio"/>	Irritable bowel	<input type="radio"/>	<input type="radio"/>	Abnormal pap smear
<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>	Kidney infection, stones	<input type="radio"/>	<input type="radio"/>	Frequent vaginal infections
<input type="radio"/>	<input type="radio"/>	Cerebral Palsy	<input type="radio"/>	<input type="radio"/>	Migraine headaches	<input type="radio"/>	<input type="radio"/>	Bladder infections
<input type="radio"/>	<input type="radio"/>	Chicken pox	<input type="radio"/>	<input type="radio"/>	Mononucleosis	<input type="radio"/>	<input type="radio"/>	Pregnancy
<input type="radio"/>	<input type="radio"/>	Colitis, ulcerative/Crohn's disease	<input type="radio"/>	<input type="radio"/>	Pneumonia	MALES ONLY		
<input type="radio"/>	<input type="radio"/>	Concussion	<input type="radio"/>	<input type="radio"/>	Rheumatic fever	<input type="radio"/>	<input type="radio"/>	Testicular mass or lump
<input type="radio"/>	<input type="radio"/>	Congenital defect	<input type="radio"/>	<input type="radio"/>	Rheumatoid, other arthritis	<input type="radio"/>	<input type="radio"/>	Bladder infection
<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	Scoliosis	<input type="radio"/>	<input type="radio"/>	Prostate infection
<input type="radio"/>	<input type="radio"/>	Epilepsy, seizures	<input type="radio"/>	<input type="radio"/>	Thyroid problems	<input type="radio"/>	<input type="radio"/>	Breast mass or enlargement
<input type="radio"/>	<input type="radio"/>	Hay fever	<input type="radio"/>	<input type="radio"/>	Tuberculosis or positive PPD	<input type="radio"/>	<input type="radio"/>	Steroid use

Do you have a medical disability or physical limitation? _____

Is there a loss or serious impaired function of any of your organs? _____

▶ FAMILY HISTORY Has any family member in the last two generations (siblings, parents, grandparents) had any of the following? If yes, who and when?

Y	N	Has a family member had?	Who?	Y	N	Has a family member had?	Who?
<input type="radio"/>	<input type="radio"/>	Stroke, blood vessel disease	_____	<input type="radio"/>	<input type="radio"/>	Heart disease	_____
<input type="radio"/>	<input type="radio"/>	Cancer	_____	<input type="radio"/>	<input type="radio"/>	High blood pressure	_____
<input type="radio"/>	<input type="radio"/>	Diabetes	_____	<input type="radio"/>	<input type="radio"/>	Liver disease	_____
<input type="radio"/>	<input type="radio"/>	Depression, suicide	_____	<input type="radio"/>	<input type="radio"/>	Genetic disorders	_____
<input type="radio"/>	<input type="radio"/>	Alcoholism	_____	<input type="radio"/>	<input type="radio"/>	Other: _____	_____
<input type="radio"/>	<input type="radio"/>	Blood clots in legs, lungs	_____	<input type="radio"/>	<input type="radio"/>	Other: _____	_____

▶ ADDITIONAL INFORMATION

Is there anything about your physical, mental or emotional health that would be helpful to Student Health Services in providing you with medical care?

▶ READ, CHECK AND SIGN BELOW

- I am aware that Esry Student Health Center charges for services. I accept personal responsibility for the payment of incurred charges that will be placed on my MWSU account in the business office if not paid by cash or check at time of service.
- I understand that I am responsible for filing outpatient charges with my private health insurance carrier and acknowledge that my responsibility to the University is unaffected by the existence of health insurance coverage.
- I understand that MWSU offers student health insurance which is the only insurance accepted and filed at Esry Student Health Center.
- I have personally supplied the above information and attest that it is true and complete to the best of my knowledge. I understand that the information contained on this form and in my medical records is strictly confidential and will not be released to anyone other than my healthcare provider, without my written authorization unless required by law. If I should be ill or injured or otherwise unable to sign the appropriate medical release form, I give my permission to MWSU Esry Student Health Center to release information from my medical record to a physician, hospital, or other medical professional involved in providing me with emergency treatment and/or medical care.
- I authorize any medical treatment for myself that may be advised or recommended by the medical providers at MWSU Esry Student Health Center

Signature of student

Date

Signature of legal guardian (If patient is under 18)

Date