ESRY STUDENT HEALTH CENTER
Missouri Western State University
Blum 203
4525 Downs Drive
St. Joseph, MO 64507

(816) 271-4495
missouriwestern.edu/student-services/health-center/

Health History Form

SEMESTER YOU PLAN TO ATTEND: **Fall** _____ **Spring** _____ **Summer** _____ **G-Number**_____

HAVE YOU PREVIOUSLY USED ESRY STUDENT HEALTH CENTER SERVICES? ___ NO ___ YES **SSN**_____

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

_____
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 International 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 inj., detailed instructions are required from your physician. Please contact the Health Center, 816-271-4495, 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):

_____
_____

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

Do you have a medical disability or physical limitation?_____

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

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

Y	N		EXPLANATION
O	O	**Bipolar disorder**	
O	O	**Substance abuse (alcohol, drugs)**	
O	O	**Eating disorder (anorexia, bulimia)**	
O	O	**Depression, anxiety**	

► **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?
O	O	Stroke, blood vessel disease	_____	O	O	Heart disease	_____
O	O	Cancer	_____	O	O	High blood pressure	_____
O	O	Diabetes	_____	O	O	Liver disease	_____
O	O	Depression, suicide	_____	O	O	Genetic disorders	_____
O	O	Alcoholism	_____	O	O	Other:_____	_____
O	O	Blood clots in legs, lungs	_____	O	O	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?

_____

o 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 consent 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.

_____ _____

Signature of Student Date

_____ _____

Signature of legal guardian (if student is under 18) Date