UNT | HEALTH PATIENT SERVICES

Student Health
3400 Camp Bowie Blvd., Suite 113
Fort Worth, Texas 76107
Phone: 817-735-5051 Fax: 817-735-0651

Medical Records

Last name | First name | Middle initial | Date of birth

Home address | City | State | Zip | Home phone number

Social Security number | Biological Sex (circle): Male Female | Gender Identity: _____

College (circle): TCOM Physician Assistant PT Pharmacy

In Case of Emergency, Notify:

Name | Relationship

Home address | City | State | Zip | Home phone number

Work address | City | State | Zip | Work phone number

History

Acne	☐ Current	☐ Past ☐ Never	Hypoglycemia (low blood sugar)	☐ Current	☐ Past ☐ Never
ADD/ADHD	☐ Current	☐ Past ☐ Never	Infectious mononucleosis	☐ Current	☐ Past ☐ Never
AIDS, ARC, or positive HIV	☐ Current	☐ Past ☐ Never	Irritable bowel disease	☐ Current	☐ Past ☐ Never
Allergies	☐ Current	☐ Past ☐ Never	Kidney infections/stones	☐ Current	☐ Past ☐ Never
Anemia	☐ Current	☐ Past ☐ Never	Knee injury	☐ Current	☐ Past ☐ Never
Anxiety disorder	☐ Current	☐ Past ☐ Never	Learning disability	☐ Current	☐ Past ☐ Never
Asthma	☐ Current	☐ Past ☐ Never	Migraine headache/Vascular H/A	☐ Current	☐ Past ☐ Never
Back problems	☐ Current	☐ Past ☐ Never	Obesity (more than 20 lbs. overweight)	☐ Current	☐ Past ☐ Never
Bladder infection (cystitis)	☐ Current	☐ Past ☐ Never	Ovarian cyst	☐ Current	☐ Past ☐ Never
Bleeding trail/sickle cell	☐ Current	☐ Past ☐ Never	Pelvic infection	☐ Current	☐ Past ☐ Never
Bronchitis- chronic	☐ Current	☐ Past ☐ Never	Peptic ulcer (gastric or duodenal)	☐ Current	☐ Past ☐ Never
Cancer (location)	☐ Current	☐ Past ☐ Never	Phlebitis	☐ Current	☐ Past ☐ Never
			Pneumonia	☐ Current	☐ Past ☐ Never
_____			Rheumatic fever	☐ Current	☐ Past ☐ Never
Chlamydia	☐ Current	☐ Past ☐ Never	Rheumatoid arthritis	☐ Current	☐ Past ☐ Never
Colitis	☐ Current	☐ Past ☐ Never	Sinus problem- chronic	☐ Current	☐ Past ☐ Never
Condyloma (genital warts-HPV)	☐ Current	☐ Past ☐ Never	Suicide attempt	☐ Current	☐ Past ☐ Never
Depression	☐ Current	☐ Past ☐ Never	Syphilis	☐ Current	☐ Past ☐ Never
Diabetes	☐ Current	☐ Past ☐ Never	Thyroid problem	☐ Current	☐ Past ☐ Never
Drug dependency	☐ Current	☐ Past ☐ Never	Tension headaches	☐ Current	☐ Past ☐ Never

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Name: _____ DOB: _____

Eating disorder	☐ Current	☐ Past	☐ Never	Tuberculosis	☐ Current	☐ Past	☐ Never
Eczema	☐ Current	☐ Past	☐ Never	Vaginitis (recurrent)	☐ Current	☐ Past	☐ Never
Emotional/mental illness	☐ Current	☐ Past	☐ Never	Varicella (chickenpox)	☐ Current	☐ Past	☐ Never
Epilepsy/seizures	☐ Current	☐ Past	☐ Never	Other problem not listed (specify)			
Eye problem (specify)	☐ Current	☐ Past	☐ Never				
_____				_____			
Fainting	☐ Current	☐ Past	☐ Never	Injuries, surgeries, and hospitalizations			
Gallbladder problems	☐ Current	☐ Past	☐ Never				
Gonorrhea	☐ Current	☐ Past	☐ Never	_____			
Gout	☐ Current	☐ Past	☐ Never				
Hay fever	☐ Current	☐ Past	☐ Never	Dietary needs _____			
Hearing loss	☐ Current	☐ Past	☐ Never				
Heart problems (specify)	☐ Current	☐ Past	☐ Never	_____			
_____							
Rheumatic heart disease	☐ Current	☐ Past	☐ Never	Smoking status ☐ Yes ☐ No # per day _____			
Heart murmur	☐ Current	☐ Past	☐ Never				
Hepatitis	☐ Current	☐ Past	☐ Never	Have you traveled outside of the U.S. in the past yes? ☐ Yes ☐ No			
Herpes (genital)	☐ Current	☐ Past	☐ Never				
High blood pressure	☐ Current	☐ Past	☐ Never	Where? _____			

Current Health Information

Mental Health History:

Have you ever received psychiatric care/counseling?	☐ Yes	☐ No	☐ Currently
Have you ever been hospitalized for psychiatric care?	☐ Yes	☐ No	
Have you ever been treated for an eating disorder?	☐ Yes	☐ No	
Have you ever been treated for alcohol or drug dependency?	☐ Yes	☐ No	

List all current prescription medications:

Medication name	Prescribing provider	Phone number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any known allergies? ☐ Yes ☐ No

If "yes", please list:

_____	_____	_____
_____	_____	_____

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Name: _____ DOB: _____

History of POSITIVE TB Test

Date of test: _____ / _____ / _____
Test used: _____
CXR results: _____
Follow up: _____ / _____ / _____

Family History: Age Status of health Occupation If deceased, age and cause of death

Mother _____

Father _____

Siblings _____

_____

_____

_____

Are you adopted? ☐ Yes ☐ No

You are invited to discuss your answers or any health issues with the Student Health Clinic professional staff.

The information that I have provided on this health form is accurate, to the best of my knowledge. I understand that all information is maintained as confidential within the Student Health Clinic.

_____

Student's signature Date

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Name: _____ DOB: _____

Physical Exam

To be completed by a physician, physician assistant, or nurse practitioner within a year of admission.

_____

Pt. last name Pt. first name Pt. middle initial

BP _____ Heart Rate _____ Height (in.) _____ Weight (lbs.) _____ M F Biological sex (circle)

Examination Findings (Describe fully. Use additional sheets if necessary.)

	NL	ABN	Findings (describe)		NL	ABN	Findings (describe)
General appearance	☐	☐	_____	Neck	☐	☐	_____
Skin	☐	☐	_____	Chest	☐	☐	_____
Head	☐	☐	_____	Heart	☐	☐	_____
Eyes	☐	☐	_____	Abdomen	☐	☐	_____
Nose/sinus	☐	☐	_____	Extremities	☐	☐	_____
Mouth	☐	☐	_____	Neuro	☐	☐	_____

General comments _____

_____

Is the patient now under treatment for any medical or emotional condition? ☐ Yes ☐ No

_____

_____

_____

_____

_____

Practitioner's signature Phone number

_____

Print last name Date

_____

Address City State Zip

Next steps: Please submit this form to Medicat