Medical Records

Last name First name Middle initial Date of birth

Home address City State Zip Home phone number

Biological Sex (circle): Male Female Gender Identity:

Social Security number

College (circle): TCOM GSBS SPH 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

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 year?  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:

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

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

Clinic Stamp Date

Address City State Zip

**Next steps: Please submit this form to Medicat**