

UNIVERSITY OF TENNESSEE, KNOXVILLE
STUDENT HEALTH SERVICE

MEDICAL HISTORY QUESTIONNAIRE

PLEASE PRINT OR TYPE

Name _____
(Last) (First) (Middle) (Name you prefer to be called)

Local Address _____ Gender: (Circle) M F

City: _____ State: _____ Zip: _____

Local Phone: () _____ Date of Birth / / _____ SSN: _____
Month Day Year

IN CASE OF EMERGENCY, NOTIFY: Name: _____ Relationship: _____

Telephone: (Home) () _____ (Work) () _____

Permanent Address, if Different _____

In the event hospitalization or major medical treatment should be necessary, please provide the following:

Primary Care Physician: _____ Office Phone: () _____

Medical Insurance Company: _____

Policy Holder: _____ Policy #: _____

Group #: _____ Identification #: _____

Medical History Please list:

- ◆ Drug or medication **allergies or adverse reactions**: _____
- ◆ Routine **prescription** medications that you take (name, dosage): _____
- ◆ **Over-the-counter** medications(include supplements, herbals, vitamins) used more than once per week: _____

Hospitalizations/Surgery/Procedures Please list:

- ◆ Any Hospitalizations (include diagnosis and date): _____
- ◆ Operations/Surgery (include diagnosis and date): _____
- ◆ Medical Procedures (Ultrasound, Endoscopy, CT, MRI): _____

Family History: Please place a check mark if your parents, brothers or sisters have had any of the following.

- | | | |
|----------------------|-----------------------------------|---------------------------|
| _____ Arthritis | _____ Sickle Cell Anemia/Trait | _____ High Blood Pressure |
| _____ Asthma | _____ Colon Cancer | _____ High Cholesterol |
| _____ Diabetes | _____ Breast Cancer | _____ Alcoholism |
| _____ Ovarian Cancer | _____ Depression/Bipolar Disorder | _____ Other |

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Please place a check mark beside any of the following that you have had:

- | | | |
|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety/Panic disorder | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Depression/Bipolar Disorder | <input type="checkbox"/> Frequent Headaches/Migraines |
| <input type="checkbox"/> Sickle Cell Anemia/Trait | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cancer/Tumor (type) _____ | <input type="checkbox"/> Sleep disorder | <input type="checkbox"/> Muscle/Joint Disorders |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Chemical/Alcohol dependency | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Hay fever/Allergies | <input type="checkbox"/> Physical/Sexual Abuse | <input type="checkbox"/> Visual Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stomach Ulcers/Reflux | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Gallbladder Disorder | <input type="checkbox"/> Physical impairments: list below
_____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis/Positive Skin Test |
| <input type="checkbox"/> Heart Condition/Murmur | <input type="checkbox"/> Colon disorder (Crohn's, Ulcerative Colitis,
Irritable Bowel) | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Other Significant Health
Problems (list) _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Frequent Urinary Tract Infections | |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sexually Transmitted Infection | |

Please explain any positive answers _____

Women's Health:

Age at your first menstrual period: _____ Number of days your period usually lasts: _____
 Date of your last Pap smear: _____ Abnormal Pap smear ever? _____ If so, date: _____
 Number of Pregnancies: _____ Number of children: _____
 List any hormones or oral contraceptives that you take: _____
 ♦ **Have you ever had** Breast disorders _____; Ovarian cysts _____; Endometriosis _____; Pelvic infections _____

Health Habits Assessment: Please place a check mark beside any of the following that apply:

- | | |
|---|--|
| <input type="checkbox"/> Drink alcohol – if so, number of drinks per week _____ | <input type="checkbox"/> Feel unsafe in a current relationship |
| <input type="checkbox"/> Smoke cigarettes/cigars | <input type="checkbox"/> Exercise regularly (3 – 4 times per week) |
| <input type="checkbox"/> Use snuff/chewing tobacco | <input type="checkbox"/> Are you sexually active |
| <input type="checkbox"/> Use seat belts | |

Learning Needs: Please list any **Language Barriers, Learning Disabilities, Physical Disabilities or Cultural/Religious** issues that may affect **Medical care.** _____

Student's Signature _____

Date: _____

If you have a medical problem which might require attention during your period of attendance, it would assist your student health physician to have a report from your private physician regarding that condition. Records should be submitted to:

**Medical Records Department
 University of Tennessee
 Student Health Service
 1818 Andy Holt Avenue
 Knoxville, TN 37996-2800**

*Receipt of this form by the Student Health Service does not constitute the establishment of a doctor-patient relationship. This is established only after an eligible student is first seen at the Student Health Clinic.

FOR OFFICE USE ONLY

Reviewed by: _____
 Date: _____