Kent State University Health Services

Medical History Form

1. This form must be returned to the Student Health Service prior to being seen at UHS.
2. This form will become a part of the Student Medical Record and will be treated as per our Privacy Notice.

***If you are under 18 years old, please see receptionist before filling out form***

### Primary Person to Notify in Case of an Emergency (Parent/Guardian)

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Business Phone</th>
<th>Cell Phone</th>
</tr>
</thead>
</table>

**ALLERGIES:**

- NONE

**Medications/Serums/other substances:**

- Please List

**Your Medical History:**

- NONE

- Check Mark all that apply and *explain below*

<table>
<thead>
<tr>
<th>☐ Anxiety</th>
<th>☐ Diabetes</th>
<th>☐ Hepatitis/Liver Problems</th>
<th>☐ Thyroid Disorder</th>
<th>☐ Arthritis</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Asthma/Lung Disease</td>
<td>☐ Eating Disorder</td>
<td>☐ Cholesterol Disorder</td>
<td>☐ Anemia</td>
<td>☐ Other</td>
</tr>
<tr>
<td>☐ Blood Disorder/Clots</td>
<td>☐ Seasonal Allergies</td>
<td>☐ Low/High Blood Pressure</td>
<td>☐ Abuse</td>
<td></td>
</tr>
<tr>
<td>☐ Breast Disorder</td>
<td>☐ Stomach/Digestive Disorder</td>
<td>☐ Kidney Disorder</td>
<td>☐ Psychological Disorder</td>
<td></td>
</tr>
<tr>
<td>☐ Cancer (specify type)</td>
<td>☐ Gynecological Disorder</td>
<td>☐ Mono</td>
<td>☐ Seizures</td>
<td></td>
</tr>
<tr>
<td>☐ Head Injury</td>
<td>☐ Migraines</td>
<td>☐ Musculoskeletal/Back</td>
<td>☐ Childbirth</td>
<td></td>
</tr>
<tr>
<td>☐ Depression</td>
<td>☐ Heart Disease/Heart Murmur</td>
<td>☐ Skin Disorder</td>
<td>☐ Vision/Hearing Problems</td>
<td></td>
</tr>
</tbody>
</table>

*Additional Information*

**Disability (Specify Type):**

- None

Have you felt depressed or suicidal in the last 12 months? 

- YES
- NO

If yes, list any counseling, medications and/or hospitalizations:

Please list any surgeries and hospitalizations:

- None

Please turn over and complete back of form.
**MEDICATIONS**  □ NONE

(List all medications currently being taken with dosage, frequency and condition for which it is being taken)

<table>
<thead>
<tr>
<th>Medications</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Social History**

- Alcohol Use: Amount/Frequency __________________________ □ Never □ Quit
- Tobacco Use: Currently smoke _________ Cigarettes/day □ Never □ Quit
- Drug Use: Type/Frequency ___________________________ □ Never □ Quit

**Family Medical History**  □ NONE

If any of your immediate family had/have the following check the box indicating which family member it applies to:

<table>
<thead>
<tr>
<th>Father</th>
<th>Mother</th>
<th>Sibling</th>
<th>Grandparent</th>
<th>Father</th>
<th>Mother</th>
<th>Sibling</th>
<th>Grandparent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol/Drug Addiction</td>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Clots</td>
<td>Psychological Illness</td>
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</tr>
<tr>
<td>Cancer ________</td>
<td>Kidney Disease</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Stroke</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td>Thyroid Disorder</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Elevated Cholesterol</td>
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</tr>
</tbody>
</table>

□ Adopted, no history known □ Adopted, history known __________________________

**Medical Restrictions/Advance Directive**

Do you have any medical restrictions associated with religious practices? □ YES □ NO
If yes explain:
____________________________________________________________________________________________

Do you have a living will (advance directive)? □ YES □ NO

Would you like information about advance directives? □ YES □ NO

**Consent, Release and Fee Responsibility Disclosure**
I consent to the examinations, tests, and treatments which may be done by my clinician(s) and health center staff during my visits. I understand I have the right to discuss and ask questions about my treatment.

In case of emergency, I authorize the Director of Health Services or the medical staff to notify the parent or guardian named on this form if I am unable to do so. In that event, I further authorize the medical staff to make referrals for hospitalization and to release pertinent medical information necessary for my care.

I authorize University Health Services to use this form as consent for release of medical information to consulting/referring specialists and insurance carriers for claim payment purposes.

I understand that all fees incurred for services at University Health Services are my responsibility. University Health Services will bill most major medical plans provided that accurate information is provided by patients within 48 hours of their visit to the Health Center. Kent State University also sponsors a student insurance plan which is recommended for all students without adequate insurance coverage. Charges for non-covered services are the responsibility of the patient and will be billed to students’ bursar accounts. Patients without insurance coverage are eligible to utilize the self pay fee schedule. An itemized accounting statement is available by request to all patients visiting the Health Center.

I understand the contents of the above statements, and my signature is a voluntary act. This authorization shall remain in effect until revoked in writing. A photocopy of this authorization shall be deemed as valid as the original.

___________________________________   _____________ _____________________
Printed Name

___________________________________   _____________ _____________________
Signature of Student      Date

__________________________________   ______________ ____________________
2nd (Reviewed History)       Initials

__________________________________   ______________ ____________________
3rd (Reviewed History)       Initials

__________________________________   ______________ ____________________
4th (Reviewed History)       Initials

__________________________________   ______________ ____________________
5th (Reviewed History)       Initials

_________________________________________________________ ______________
Signature of parent/ guardian (If student is under 18 years of age)    Date

Revised 9/10cp