Health Clinic

Medical History Student Questionnaire

(Please Complete Both Sides of Form in Ink)

P.O. Box 775
(405) 466-3335

Today's Date: ____________________

NAME: ____Male_____ Female_____
(Last) (First) (Middle)

Campus Student ID #______________________ **Date of Birth** _________________________

Citizenship U.S. _____ Other (Specify): ____

Student Contact Information: Cell Phone: _____________________________

Student E-mail Address: ____

May we contact you on your cell phone if needed? ____Yes ____No

Do we have your permission to leave a voice message on your cell phone? ____Yes ____No

EMERGENCY CONTACT INFORMATION

Name _________________________________Relationship _____________________Phone: ______________________

Please describe current symptoms that bring you to the Health Clinic today:

____

____

Do you feel like you are running a fever? ____Yes ____No

Have you travelled outside the country in the past 3 weeks? _____Yes _____ No

If you have travelled outside the country in the past 3 weeks, please describe where: ____________________________

MEDICAL HISTORY— Have you ever had any of the following (check if applicable):

___Alcohol Abuse
___Anemia
___Arthritis
___Asthma
___Back Problems
___Chronic Cough
___Cancer
___Colitis
___Convulsions/Seizures
___Depression
___Diabetes
___Disability
___Drug Abuse
___Eating Disorder

___Chronic Hay fever
___Hepatitis
___Headache (Chronic/Migraine)
___Heart Disease
___Head Injury
___Hernia
___High Blood Pressure
___High Cholesterol
___Heart Murmur
___Hemophilia
___Intestinal/Stomach Disorders

___Malaria
___Kidney Disease
___Mononucleosis
___Menstrual (Problems/Pain)
___Orthopedic Problems
___Pneumonia
___Polio
___Psychological Counseling
___Sickle Cell Disease
___Rheumatic Fever
___Mumps

___Loss of Consciousness/Fainting
___Sleep Disorder
___Stroke
___Tuberculosis (TB)
___Thyroid Disease
___Spleen Removed
___Measles
___Chronic Sinus Infections
___Chicken Pox
___Chronic Bladder/Urinary Infections

Brief Explanation of any **Checked** Responses:
____
____
____

History of Surgery: Yes No Ongoing Medical Problems: Yes No (If Yes, List Below):
____
____

Environmental Allergies: ____________________________
____

List current medications:
____
____
____
____
____

Medication Allergies: Yes No
(List Medication/Reaction): __________________________
____

Herbs:___________________________________

Tobacco Use: Yes No
Type: ____________________________________ Frequency:____

ALL INFORMATION PROVIDED IS CONFIDENTIAL

AUTHORIZATION FOR MEDICAL TREATMENT

For All Students:

By signature, I verify that the information on this form is accurate and true. By signature I give permission for diagnosis, therapeutic, and operative procedures as may be deemed necessary for me.

Signature ____ Printed Name ____________________________ Date ______________

For all students under 18 years of age:

I authorize the Langston University Health Clinic to administer medical and surgical services, immunizations, and therapeutic procedures as deemed necessary by licensed provider.

Parent's or Guardian's Signature ___________________________ Relationship ____________________________ Date ______________