SOUTHWEST
MINNESOTA STATE UNIVERSITY

HEALTH SERVICES

REPORT OF MEDICAL HISTORY

As a student, it is your responsibility to provide an accurate past medical history.
All information is held confidentially within Health Services at Southwest Minnesota State University.
Please complete before entering college.

Last Name (Family Surname) *First Name (Given-Personal)* *Middle Name*

Home Address (Number and Street) *City or Town* *State* *Zip* *Country* **Date of Birth (MM/DD/YY)*

Emergency Contact Name and Relationship *Home Telephone*

Emergency Contact Address *Business Telephone*

_____ Gender: Male [ ] Female [ ]
**Social Security Number of Student*

**Many colleges/universities use Social Security numbers for student identification purposes on student records. Providing your Social Security number, gender, and date of birth is voluntary. If you do not provide this number, this information will still be processed. This data is requested for purposes of administration, program evaluation, and consumer and alumni data. Your number also may be used to create summary information about MnSCU programs through data matches with other state agencies.*

SEMESTER ENTERING: *Circle Term*: Fall Spring Summer Session I or II *Year:* 20____

HAVE YOU OR ANY OF YOUR RELATIVES HAD ANY OF THE FOLLOWING?

AILMENT	YES	NO	RELATIONSHIP	AILMENT	YES	NO	RELATIONSHIP
Tuberculosis				Diabetes			
Kidney Disease				Heart Disease			
Arthritis				Stomach Disease			
Asthma				Hay Fever			
Seizure Disorder				Cancer			

PERSONAL HISTORY: PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers in the space on the back side of this sheet.

HAVE YOU HAD:	YES	NO	HAVE YOU HAD:	YES	NO	HAVE YOU HAD:	YES	NO	HAVE YOU HAD:	YES	NO
Chicken Pox			Insomnia			Pain/Pressure in Chest			Gallstones		
Malaria			Frequent Anxiety			Chronic Cough			Recurrent Diarrhea		
Gum/Tooth Trouble			Depression			Heart Palpitations			Rupture, Hernia		
Sinusitis			Nervousness/Worry			High/Low Blood Pressure			Recent Weight Gain		
Eye Trouble			Recurrent Headaches			Rheumatic Fever			Recent Weight Loss		
Ear/Nose/Throat Trouble			Recurrent Colds			Heart Murmur			Dizziness, Fainting		
Surgery:			Head Injury with Unconsciousness			Joint Disease			Weakness, Paralysis		
Appendectomy						Joint Injury			Seizures		
Tonsillectomy			Hay Fever, Asthma			"Trick" Joint (Knee, Shoulder)			Venereal Disease		
Hernia Repair			Tuberculosis			Back Problems			Albumin/Sugar in Urine		
Immunization Data: *(Most recent date)*			Shortness of Breath			Tumor or Cyst			AIDS or HIV		
Measles/Mumps/Rubella Year:_____			**Allergic Reactions:**			Cancer			**Menstrual History:**		
Tetanus/Diphtheria Year:_____			Penicillin			Jaundice			Age at Onset		
Hepatitis B No Yes/Year:_____			Sulfonamides			Stomach Problems			Irregular Periods		
Meningococcal No Yes/Year:_____			Serum			Intestinal Problems			Severe Cramps		
HPV No Yes/Year:_____			Foods (which)			Urinary Problems			Excessive Flow		
Varicella No Yes/Year:_____						Gallbladder Trouble			Other:		
			Other:			Recurrent Infections					

Height: _____Inches (_____Centimeters) **Weight:** _____lbs. (_____Kilograms)

Continue on the other side.

Please answer the following questions (Give dates and details):

1. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the last 5 (five) years, other than routine?_____

_____

2. Have you had any major injuries or operations? [ ] YES [ ] NO
   If YES, what kind and when: _____

_____

3. Has your physical activity been restricted during the past 5 (five) years? [ ] YES [ ] NO
   If YES, describe: _____

_____

4. Have you received treatment or counseling for a nervous condition, personality or character disorder, emotional problem or chemical dependency? [ ] YES [ ] NO
   If YES, what kind and when: _____

_____

5. Are you taking medication regularly? [ ] YES [ ] NO
   If YES, what kind and when: _____

_____

6. Do you have any physical disabilities such as paralysis, loss of vision, impaired hearing, etc.? [ ] YES [ ] NO
   If YES, describe: _____

_____

7. List below any hospital, illness or health insurance you carry. Please indicate policy numbers. Southwest Minnesota State University recommends all students carry health insurance.

_____

_____

_____

Additional Comments or Information: (If more space is needed, please attach additional sheets identified with name and social security number.)

TREATMENT CONSENT AND RELEASE

In case of accident or illness, I give the University and its representative(s) full permission to secure medical, dental and/or surgical care which may include transport to a doctor or hospital of their choice, injection, examination, medication, and surgery that is considered necessary for my good health. I agree to pay all off-campus medical costs and fees, including costs and fees for all emergency medical treatment and transportation, in these events, I understand and agree that the University does not have any liability or responsibility for any injury or damage that may arise from such medical, dental and/or surgical care.

Student's Signature_____ Date:_____

If the student is under 18 years of age at the time of enrollment, a parent or guardian's signature is required before medical treatment can be provided.

Parental Signature_____ Date:_____