TENNESSEE STATE UNIVERSITY
STUDENT HEALTH SERVICES
MEDICAL HISTORY QUESTIONNAIRE

PLEASE PRINT CLEARLY.

NAME _____
Last First Middle

LAST 4 DIGITS OF SSN _____ BIRTHDATE _____ AGE _____

PERMANENT ADDRESS _____

CITY_____ STATE _____ ZIP CODE_____

HOME PHONE (_____) _____ CELL PHONE (_____) _____

E-MAIL ADDRESS _____

DO YOU HAVE HEALTH INSURANCE? _____
IF SO, COMPANY AND POLICY#. _____

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? Please Circle.

Asthma	Hypertension	Rheumatic Fever
Diabetes	Migraine Headaches	Seizure Disorders
Heart Disease	Peptic Ulcers	Tuberculosis

OTHER SERIOUS MEDICAL CONDITION(S) _____

HAVE YOU EVER BEEN TREATED FOR A NERVOUS OR EMOTIONAL CONDITION? _____
IF SO, PLEASE EXPLAIN. _____
_____

LIST ANY MEDICATIONS THAT YOU TAKE REGULARLY.

_____ _____ _____

_____ _____ _____

LIST ANY MEDICATIONS TO WHICH YOU ARE ALLERGIC.

_____ _____ _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

NAME _____ RELATIONSHIP _____

CONTACT NUMBER(S) _____

If a student is under 18 years of age, we need permission to treat the student/hospitalize for a serious illness at the discretion of the Student Health Center physician. Parent, please sign, if applicable. Parent (Guardian) _____ Date _____

SIGNATURE OF STUDENT _____ DATE_____