TENNESSEE STATE UNIVERSITY
STUDENT HEALTH SERVICE

MEDICAL HISTORY QUESTIONNAIRE

PLEASE PRINT CLEARLY

NAME_____
Last First Middle

SOCIAL SECURITY #_____BIRTHDATE_____

HOME ADDRESS_____
Street City State Zip

TELEPHONE: HOME _____
Area Code Number

NAME OF INDIVIDUAL TO NOTIFY IN CASE OF EMERGENCY_____
_____RELATIONSHIP_____

ADDRESS_____

TELEPHONE_____

DO YOU HAVE ANY INSURANCE?_____

COMPANY AND POLICY#_____

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (please circle):

Asthma Seizure Disorder Hypertension Sickle Cell Anemia Peptic Ulcer
Diabetes Heart Disease Migraine Rheumatic Fever Tuberculosis

OTHER SERIOUS DISEASE_____

HAVE YOU EVER TREATED FOR A NERVOUS OR EMOTIONAL CONDITION ? _____/_____
Yes No

PLEASE EXPLAIN_____

LIST ANY MEDICINE TAKEN REGULARLY OR OCCASSIONALLY:_____
MEDICATIONS (S) TO WHICH YOU ARE ALLERGIC_____

IF A STUDENT IS UNDER 18 YEARS OF AGE WE NEED PERMISSION TO TREAT THE STUDENT OR HOSPITALIZE FOR A SERIOUS ILLNESS AT THE DISCRETION OF THE STUDENT HEALTH PHYSICAN. PARENT PLEASE SIGN BELOW IF APPLICABLE.

DATE_____SIGNATURE OF PPLICANT_____

PARENT OR GUARDIAN_____

IMPORTANT: Make a copy of this form for your personal record