

**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 or (Guardian) _____ **Date** _____

SIGNATURE OF STUDENT _____ **Date** _____

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