MEDICAL HISTORY
Taylor Health and Wellness Center
Missouri State University
901 South National
Springfield, MO 65897
(417) 836-4000 (phone) / (417) 836-4133 (fax

University ID # ________________________ Date: ______________________
Date of Birth:_______________
Status: __ Student __ Faculty ___ Staff __ Dependent __ Other ________ Marital __S __M __W __D

Name ____ Date of Birth
Last First Middle

Home Address ______________________________ Preferred Phone ( )
Street City or Town State Zip Code

In an emergency, contact ______________ ( ) ( )
Name Preferred Phone Work Phone Relationship

Do you have insurance? __ Y __ N **Present your current insurance card on each visit.**

If you are a dependent or household member of MSU employee or student, give their name and their University ID #: ________________________

FAMILY HISTORY

	Age	State of Health	Occupation	IF DECEASED Cause of Death	Age of Death
Father					
Mother					
Brothers					
Sisters					

Have **YOU OR ANY OF YOUR BLOOD RELATED FAMILY MEMBERS** *had*

	YES	NO	RELATIONSHIP
Cancer (List type)			
High blood pressure			
Bleeding disorder			
Tuberculosis			
Diabetes			
Kidney disease			
Heart disease			
Arthritis			
Gastrointestinal disorder			
History of drug/alcohol abuse			

PERSONAL HISTORY: ANSWER ALL QUESTIONS RELATED TO YOUR PAST HEALTH HISTORY. *Comment on positive answers in space below or on additional sheet.*

HAVE YOU HAD?	YES	NO		YES	NO		YES	NO		YES	NO
			ALLERGY or SENSITIVITY to Medications: Please list			Recurrent colds or chronic cough			Disease or Injury of bones or joints		
Measles						Shortness of Breath			Back problems		
German Measles						Asthma and/or hay fever			Weakness, Paralysis		
Mumps						Pain/Pressure in Chest			Dizziness, Fainting		
Chicken Pox			to **Foods:** Please list			Heart murmur			Frequent Urination		
Malaria						Rheumatic fever			Kidney disease		
Gum or Tooth Problem			**to Pollens/Animals/Materials/Other: Please list**			High or Low Blood Pressure			Sexually Transmitted Infection		
Sinusitis			Head injury/ unconsciousness or concussion			Recurrent diarrhea or constipation or both			Chronic skin disease eczema or psoriasis		
Eye Problem			Seizure disorder/Epilepsy			Jaundice or Hepatitis			Tumor, cancer, cyst		
Ear, Nose, Throat Problems			Recurrent or severe headache, migraine headache			Gallbladder disease or gallstones			Tuberculosis		
									FEMALES ONLY		
Surgery: List			Worry or Nervousness			Eating disorder anorexia or bulimia			Excessive flow		
			Insomnia						Irregular Periods		
			Frequent Anxiety			Hernia, rupture			Severe Cramps		

A. Has your physical activity been restricted during the past five years? (give reasons and duration)		
B. Have you ever had radiation treatments to the head or neck?		
C. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem?		
D. Have you had any illness or injury or been hospitalized, other than already noted? (Give details)		
E. Have you been rejected for or discharged from military service because of physical, emotional, or other reasons?)		
F. Have you lived or traveled outside of the U.S.A.?		

G. **List medications** you take regularly including non-prescription & herbals.

H. Name and address of your primary care physician.
____
____

I. A physical exam is not required. If you have had a significant medical problem, have your physician send information about your medical history to this address.

HIPAA Notice of Privacy Practices Acknowledgement

__ I agree to receive Taylor's Notice of Privacy Practices (April 14, 2003 version) electronically that can be reviewed and printed at http://health.missouristate.edu,; or,

__ I acknowledge receipt of this Notice and that updates will be made available at this website, can be received at Taylor any time, and is posted in Taylor.

Check **one** of the above and sign, here ____ Date_____________
(*If less than age 18 then Parent or Legal Guardian)*

CONSENT FOR TREATMENT OF MINORS (UNDER 18 YEARS OLD) **MUST BE COMPLETED FOR CARE TO BE GIVEN TO MINORS**

I AUTHORIZE TREATMENT OF, ____ Date of Birth ___________________
Last name First Middle

Signature (Parent /Legal Guardian)____Relationship__________________ Date ___________

. Please complete Vaccination record also

Rev.03/2009

IMMUNIZATION RECORD

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University ID #______________________ Date: _________________

NAME ____ Date of birth:____________

Last First Middle

Please record your immunization (vaccination) history below.

1. It is very important for you to complete this document and return it to Taylor Health and Wellness Center.
2. Also you will need to know your immunization history throughout your life, to keep a copy for yourself.
3. Be sure to record new vaccinations as you receive them.
4. If you don't have a copy of your immunizations you can get a copy from your Pediatrician, Family Doctor, clinic, provider, or your high school.

IMMUNIZATIONS

(A copy of your personal record is acceptable)

	Date	Date	Date	Date	Date		Date	Date	Date
DPT Diphtheria Pertussis Tetanus						**Hepatitis A** (2 vaccinations)			
Td Tetanus Diphteria						**Hepatitis B** (3 vaccinations)			
Tdap Tetanus Diphteria Acellular Pertussis						**Twinrix** (3 vaccinations) (combination Hep A & B)			
Polio						**Shingles**			
MMR (2 vaccinations) Measles (Rubeola) Mumps Rubella						**Pneumococcal**			
Measles Booster (Rubeola)						**Meningococcal**			
Varicella **(2 vaccinations)** (Chickenpox)									
HPV (3 vaccinations) (Human papillomavirus)									

03/11/09