



Health Services
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HEALTH HISTORY

The University requires a medical history and updated immunizations. The information on this health form is confidential and will be used only as an aid to providing necessary health care while you are a student. You will not be permitted to register until this completed form has been received by the Herschel A. Smith Health Center. Please submit form at least four weeks before registration.

PERSONAL DATA (PLEASE PRINT IN INK OR TYPE)

Full Name
Student ID SS#
Sex M F Age Birth Date Height Present weight lbs
Marital Status S M D W Mothers Maiden name:
Home Address Telephone
E-mail address
Name of your parent/guardian Telephone
Parent/guardian's mailing address
Person to contact in an emergency Telephone
University division/school you are entering Date Entering

MEDICAL HISTORY

List medication to which you are allergic and give dates and descriptions of reactions. (If "none" please indicate.)
List and give dates (by occurrence or onset) of any major illnesses or hospitalizations you have had. (If "none" please indicate.)
List and give dates of significant injuries or surgery. (If "none" please indicate)
List medication you are taking. (Including oral contraceptives, allergy injections, herbals, etc. -If "none" please indicate.)
Do you smoke? Yes No Previously? How long? How much per week?
Do you drink alcoholic beverages? Yes No Previously? How long? How much per week?
Are you concerned about your use of alcohol, tobacco, or drugs? Yes No
Are you satisfied with your present weight? Yes No Have you had a significant weight change recently?
What, if any, restriction do you have on your physical activities?
Is there any other information which would be helpful to the Herschel A. Smith Health Center in providing you with medical care?

STUDENT NAME _____

DO YOU HAVE A PRESENT OR PAST HISTORY OF:

(Check Every Item)

Yes	No		Yes	No	
		Eye Problems			Congenital birth defects
		Ear/Nose/Sinus Problems			Cancer or malignancy
		Throat/tonsillar infections			Non-malignant tumor
		Infectious Mononucleosis			Thyroid Disorder
		Asthma			Diabetes
		Bronchitis			Epilepsy or seizures
		Tuberculosis			Headaches
		Other lung infection			Depression
		Rheumatic Fever			Anxiety or tendency to worry
		Heart murmur			Skin problems
		Chest pain			Measles(Red/Rubeola)
		Rapid heart rate			Measles(German/Rubella)
		Fainting during or after exercise			Mumps
		Ulcer (stomach/duodenal)			Chicken pox
		High blood pressure			Gynecological Problems
		Recurrent diarrhea			Herpes/other genital infections
		Colitis/Enteritis			Back Problems
		Hepatitis: Type _____			Bone or Joint Problems
		Bladder or kidney infection			Sports-related injuries
		Kidney Stone			Alcohol or Drug Use
		Anemia or blood disorder			Eating Disorder
		Blood clotting problems			Other _____

IF YES IS ANSWERED TO ANY OF THE ABOVE, PLEASE EXPLAIN AND PROVIDE DATES, TREATMENTS, AND COMPLICATIONS, ETC.

FAMILY HISTORY

Are both of your parents living? Yes _____ No _____ If no, cause of death _____

If alive, are your parents in good health? Yes _____ No _____ If no, please explain. _____

Number of siblings: Living _____ Deceased _____ Cause of death _____

Has any member of your family now or in the past had:

	Yes	No	Relation to you		Yes	No	Relation to you
Heart Disease				High Blood Pressure			
Cancer				Psychiatric Disorders			
Diabetes				Alcohol/Drug abuse			

PREVIOUS MEDICAL HISTORY

List the name and address of your family or home physician/primary care provider:

Name _____ Telephone (____) _____

Address: _____

CONSENT FOR TREATMENT AND STATEMENT OF ACCURACY

I hereby authorize the medical staff at Georgia Southwestern State University Health Services, their agents or consultants to perform diagnostic and treatment procedures which in their judgment become necessary while I am a student at Georgia Southwestern State University. I also authorize such treatment, x-rays or other diagnostic studies as, in the judgment of the provider, may be reasonably necessary to preserve and protect my health (or the health of my minor child or ward).

By my signature below, I also attest that all statements in the student medical and immunization record are true to the best of my knowledge and that I(or for my minor child or ward) have (has) no health problems or medical restrictions not listed on this record.

SIGNATURE OF STUDENT

DATE

If student is under 18 years of age, this form must be signed by the parent or guardian:

SIGNATURE OF PARENT OR GUARDIAN

DATE