HEALTH HISTORY FORM

Recommended, but not required

Missouri Western State University
Esry Student Health Center
4525 Downs Drive – Blum 203
St Joseph, MO 64507-9987
(816) 271-4495 • Fax (816) 271-4498

Date____

SEMESTER YOU PLAN TO ATTEND: **Fall**___________ **Spring**__________ **Summer**__________ **G-Number**___________________________________

HAVE YOU PREVIOUSLY USED ESRY STUDENT HEALTH CENTER SERVICES? NO YES **SSN**

____ **Date of Birth** _________________ **Age**_________ **M** **F**
Last Name **First Name** **MI**

____
Address **City** **State** **Zip**

Phone **Cell Phone**

____________________________________ ____
Country of birth **Current E-Mail**

Do you plan to live on campus? **YES** **NO** **Participate in MWSU athletics?** **NO** **YES** **Which sport?**__________________________

► HEALTH INSURANCE INFORMATION

International Student Health Insurance **Saudi Arabian Cultural Mission, Kuwait Cultural Mission, or Omani Cultural Mission Sponsored Insurance**

► EMERGENCY CONTACT INFORMATION

____
Name Relationship

____
Address City State Zip

Home Phone Work Phone Cell Phone

____
Primary Physician Address Phone Fax

► ALLERGY HISTORY

List any drug allergies: ____ Reaction: ______________________

List any allergies to materials (such as latex)______________________________ Reaction: ______________________

List any food allergies: ____ Reaction: ______________________

List any allergies to insect bites: ______________________________________ Reaction: ______________________

Are you receiving allergy injections? ** __________________________________ Reaction: ______________________

****NOTE:** If Esry Student Health Center is to administer your allergy vaccine, detailed instructions are required from your physician. Please contact the Health Center, 816-217-4495, for a packet of information to take to your allergist.

► CURRENT MEDICATIONS List any drugs, medications, birth control, vitamins, and dietary supplements you currently use:

►HOSPITALIZATION/SURGICAL HISTORY List any hospitalization and prior operations you have had, with dates (i.e. appendectomy, fracture):

► MENTAL HEALTH HISTORY **Have you ever suffered from, been treated for, or hospitalized for the following?**

Y	N		EXPLANATION
		Bipolar disorder	
		Substance abuse (alcohol, drugs)	
		Eating disorder (anorexia, bulimia)	
		Depression, anxiety	

► PERSONAL HISTORY **Indicate whether you have had any of the following medical issues**

Y	N	Have you had?
		Acne
		Anemia/Sickle cell/Other
		Asthma/Lung disease
		Bleeding problem
		Blood clots in legs or lungs
		Broken bones
		Cancer
		Cerebral Palsy
		Chicken pox
		Colitis, ulcerative/Crohn's disease
		Concussion
		Congenital defect
		Diabetes
		Epilepsy, seizures
		Hay fever

Y	N	Have you had?
		Hearing loss
		Heart murmur/other heart problems
		Hepatitis
		High blood pressure
		High cholesterol
		Irritable bowel
		Kidney infection, stones
		Migraine headaches
		Mononucleosis
		Pneumonia
		Rheumatic fever
		Rheumatoid, other arthritis
		Scoliosis
		Thyroid problems
		Tuberculosis or positive PPD

Y	N	Have you had?
		Ulcers
		Other:________________________
FEMALES ONLY		
		Irregular periods
		Breast lump or cyst
		Abnormal pap smear
		Frequent vaginal infections
		Bladder infections
		Pregnancy
MALES ONLY		
		Testicular mass or lump
		Bladder infection
		Prostate infection
		Breast mass or enlargement
		Steroid use

Do you have a medical disability or physical limitation?____

Is there a loss or serious impaired function of any of your organs?____

► FAMILY HISTORY Has any family member in the last two generations (siblings, parents, grandparents) had any of the following? If yes, who and when?

Y	N	Has a family member had?	Who?
		Stroke, blood vessel disease	_____________________
		Cancer	_____________________
		Diabetes	_____________________
		Depression, suicide	_____________________
		Alcoholism	_____________________
		Blood clots in legs, lungs	_____________________

Y	N	Has a family member had?	Who?
		Heart disease	_____________________
		High blood pressure	_____________________
		Liver disease	_____________________
		Genetic disorders	_____________________
		Other:________________	_____________________
		Other:________________	_____________________

► ADDITIONAL INFORMATION

Is there anything about your physical, mental or emotional health that would be helpful to Student Health Services in providing you with medical care?

____

____

► READ, CHECK AND SIGN BELOW

I am aware that Esry Student Health Center charges for services. I accept personal responsibility for the payment of incurred charges that will be placed on my MWSU account in the business office if not paid by cash or check at time of service.

I understand that I am responsible for filing outpatient charges with my private health insurance carrier and acknowledge that my responsibility to the University is unaffected by the existence of health insurance coverage.

I understand that MWSU offers international student health insurance which is the only insurance accepted and filed at Esry Student Health Center.

I have personally supplied the above information and attest that it is true and complete to the best of my knowledge. I understand that the information contained on this form and in my medical records is strictly confidential and will not be released to anyone other than my healthcare provider, without my written authorization unless required by law. If I should be ill or injured or otherwise unable to sign the appropriate medical release form, I give my permission to MWSU Esry Student Health Center to release information from my medical record to a physician, hospital, or other medical professional involved in providing me with emergency treatment and/or medical care.

I authorize any medical treatment for myself that may be advised or recommended by the medical providers at MWSU Esry Student Health Center

____ ____________________________

Signature of student Date

____ ____________________________

Signature of legal guardian (If patient is under 18) Date