WCU Health Center

Report of Medical History **(please print)** **Student**

PATIENT INFORMATION:

_____ _____/_____

Name (Last Name, First Name, Middle Initial) DOB Student ID

_____ _____/_____

Local/Campus Address which you would like to receive all information from the Health Center (i.e. appointment reminders, billing statements) Other Address Phone #

(_____)_____ _____

Phone Number at which you can best be reached Email Address

_____/_____ _____/_____

Emergency Contact Relationship Address Phone #

CHECK ONE:

Gender ☐ Male ☐ Female **Classification** ☐ Faculty ☐ Staff ☐ Undergraduate ☐ Graduate

Marital Status ☐ Single ☐ Married ☐ Other **Ethnicity** ☐ Caucasian ☐ Hispanic ☐ African-American ☐ Asian

Standing ☐ Part-time ☐ Full-time ☐ Native American ☐ Multi-Racial ☐ Caribbean/Islander ☐ Jamaican ☐ Other

INSURANCE INFORMATION:

Do you have health insurance? ☐ Yes ☐ No

_____ _____

Name of Health Insurance Company Address of Company

_____ _____

Name of Policy Holder Policy/Group #

FAMILY & PERSONAL HEALTH HISTORY:

Height _____ Weight _____ Do you exercise 3 or more times a week? ☐ Yes ☐ No

Personal History: Have you ever had or do you currently have any of the following:

Illness/ Injury	Yes	No	Year	Illness/ Injury	Yes	No	Year	Illness/ Injury	Yes	No	Year	Illness/ Injury	Yes	No	Year
High Blood Pressure				Mononucleosis				Frequent Vomiting				Neck Injury			
Rheumatic Fever				Hay Fever				Anorexia/ Bulimia				Back Injury			
Heart Problems				Head or Neck Radiation				Binge Eating				Broken Bones			
Pain or Pressure In Chest				Arthritis				Gall Bladder Problems or Gallstones				Bone/Joint Deformity			
Shortness of Breath				Concussion				Polio				Kidney Infection			
Asthma				Frequent/Severe Headache				AIDS				Bladder Infection			
Pneumonia				Dizziness/ Fainting				Jaundice or Hepatitis				Protein or Blood in Urine			
Chronic Cough				Severe Head Injury				Rectal Disease				Kidney Stone			
Tuberculosis				Paralysis				Hernia				Hearing Loss			
Tumor or Cancer Specify:				Epilepsy/ Seizures				Severe/Recurrent Abdominal Pain				Tobacco Use Packs/Day:			
Malaria				Depression				Severe Fatigue				Menstrual Disorder			
Thyroid Problems				Anxiety				Anemia or Sickle Cell Anemia				Sinusitis			
Serious Skin Disease				Ulcer (Duodenal or Stomach)				Eye Problems (excluding glasses)				Diabetes			
Alcohol/ Drug Use				Intestinal Problems				Knee Problems				Allergy Injections			
STD				Pilonidal Cyst				Recurrent Back Pain				Blood Transfusion			

Other (please list): _____

CONTINUED ON BACK

FAMILY & PERSONAL HEALTH HISTORY (cont'd):

Please list any drugs, medicines, birth control pills, vitamins, minerals, and dietary supplements you use:

Name	Use	Dosage

Family History: Has any person related by blood had any of the following:

Illness/ Injury	Yes	No	Relationship	Illness/ Injury	Yes	No	Relationship	Illness/ Injury	Yes	No	Relationship
High Blood Pressure				Cholesterol or High Blood Fats				Alcohol/Drug Abuse			
Stroke				Diabetes				Psychiatric Illness			
Cancer Specify:				Glaucoma				Suicide			
Heart Attack before age 55				Blood or Clotting Disorder				Other:			

Personal Medical History:

History	Yes	No	Explanation
Have you ever had surgery? Date(s):			
Have you ever been a patient in any type of hospital? When, Where, & Why:			
Has your academic career been interrupted due to physical or emotional problems?			
Is there loss or seriously impaired function of any of your paired organs?			
Other than for a routine check-up, have you seen a physician or health care provider in the past 6 months?			
Have you ever had any serious illness or injuries other than those already noted? When, Where, & Details:			
Do you have any drug allergies? Please list.			
Are you allergic to any insect bites? Please list:			
Do you have any food allergies? Please specify:			

List any other pertinent information that would be valuable to your health care providers:

_____

_____

IMPORTANT INFORMATION ABOUT YOUR CARE, PLEASE READ & SIGN BELOW:

I. I am aware that University Health Services charges for some services. I accept personal responsibility for the payment of incurred charges at the time services are rendered.

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

III. I hereby authorize any medical treatment for myself that may be advised or recommended by the medical providers of University Health Services.

IV. 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 without my written authorization, unless required by law. If I should be ill or injured or otherwise unable to sign the appropriate medical release forms, I hereby give my permission to University Health Services 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.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Legal Representative (if patient is a minor) Date

_____ _____

Signature of Reviewing Provider Date