Texas A&M International University
Student Health Services
Health History Form

PERSONAL INFORMATION

Name: _____ Sex: M F Age: _____ Date of Birth: _____
Last First M.I.

Address: _____ Phone: _____ SS#: _____
Street/P.O.Box City, State, Zip

EMERGENCY CONTACT INFORMATION

Primary Contact:

Name: _____ Relationship to child: _____

Phone Number: _____

Secondary Contact:

Name: _____ Relationship to child: _____

Phone Number: _____

DRUG AND/OR OTHER ALLERGIES
(List those your child is allergic to and type of reaction)

_____

_____

CHRONIC MEDICAL OR EMOTIONAL CONDITIONS

_____

_____

MEDICINES YOUR CHILD IS TAKING
(List medications your child is taking with or without prescription)

_____

_____

REASONS FOR LAST HOSPITALIZATIONS

_____ Approx. Year: _____

_____ Approx. Year: _____

PERSONAL HEALTH HISTORY

Females Only:

Onset of menstrual cycle: at age _____ Duration of cycle (days): _____

Check one (regarding menstrual cycle) PAIN ( ) None ( ) Mild ( ) Heavy ( ) Severe

FAMILY MEDICAL HISTORY

Has a relative (mother/father/brother/sister/grandparent) suffered from any of the following:

Check all that apply.

DESCRIPTION	Yes	No	RELATIONSHIP
Abn. Bleeding Tendency	[ ]	[ ]	
Hay Fever	[ ]	[ ]	
Anxiety	[ ]	[ ]	
Eating Disorder	[ ]	[ ]	
Obesity	[ ]	[ ]	
Depression	[ ]	[ ]	
Cancer	[ ]	[ ]	
Diabetes	[ ]	[ ]	
Epilepsy/Seizures	[ ]	[ ]	
Heart Disease	[ ]	[ ]	
High Blood pressure	[ ]	[ ]	
High Cholesterol	[ ]	[ ]	
History of Stroke at an early age (< 50 yrs.)	[ ]	[ ]	
Tuberculosis	[ ]	[ ]	
Asthma	[ ]	[ ]	
Kidney Diease	[ ]	[ ]	
Other:			

HAS THE CHILD EVER BEEN TREATED BY A PHYSICIAN FOR ANY OF THE FOLLOWING

[ ] Abnormal Bleeding	[ ] Dizziness/fainting spells	[ ] Nervous Breakdown
[ ] Alcoholism	[ ] Drug abuse	[ ] Phlebitis
[ ] Allergies to food/pollen	[ ] Eczema, hives, rashes	[ ] Pneumonia
[ ] Anemia	[ ] Epilepsy/seizures/convulsions	[ ] Rheumatic Fever
[ ] Arthritis	[ ] Eye problems	[ ] Rubella, German Measles
[ ] Asthma	[ ] Gall Bladder Disease	[ ] Sinusitis
[ ] Attention Deficit Disorder	[ ] Glaucoma	[ ] Stomach Problems
[ ] Hyperactivity Disorder	[ ] Heart Disease	[ ] Stroke
[ ] Broken Bone	[ ] Headaches	[ ] Suicide Attempt
[ ] Cancer, tumor	[ ] Hepatitis	[ ] Thyroid Disease
[ ] Chronic Back problems	[ ] Hernia	[ ] Ulcer in stomach
[ ] Chronic cough	[ ] High Blood Presure	[ ] Venereal Disease
[ ] Chronic skin problems	[ ] Mononucleosis	[ ] Vision Problems
[ ] Colitis/colon problems	[ ] Kidney Disease	[ ] Weight-recent gain or loss
[ ] Congenital heart disease	[ ] Liver Disease, Hepatitis, Yellow Jaundice	[ ] Worry/Anxiety
[ ] Depression	[ ] Lung Disease	[ ] Other diseases:
[ ] Diabetes	[ ] Menstrual Problems	
[ ] Diminished hearing	[ ] Mumps, Measles, Chickenpox	

PLEASE PROVIDE ADDITIONAL INFORMATION ON ANY ITEMS CHECKED ABOVE

AUTHORIZATION OF TREATMENT

I hereby certify that the above history is complete to the best of my knowledege and I do hereby give permission for TAMIU Student Health Services provider(s) doctors, nurse practitioner, and nurses to perform examinations, diagnostic testing, and other procedures necessary to help maintain my child's health for as long as he/she is attending Texas A&M International University and/or all special programs. I understand and give consent for protected health information to be used to carry out treatment or for other health care operator.

Print parent/legal guardian name

Signature of parent/legal guardian

Date