

**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 of Birth: \_\_\_\_\_  
 Status: \_\_\_ Student \_\_\_ Faculty \_\_\_ Staff \_\_\_ Dependent \_\_\_ Other \_\_\_\_\_

Date: \_\_\_\_\_  
 Marital \_\_\_ S \_\_\_ M \_\_\_ W \_\_\_ D

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Last First Middle Preferred Phone ( ) \_\_\_\_\_  
 Home Address 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	ALLERGY or SENSITIVITY to Medications: Please list	YES	NO	Recurrent colds or chronic cough	YES	NO	Disease or Injury of bones or joints	YES	NO
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 <b>Foods:</b> Please list			Heart murmur			Frequent Urination		
Malaria						Rheumatic fever			Kidney disease		
Gum or Tooth Problem			to <b>Pollens/Animals/Materials/Other:</b> 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		
<b>Surgery:</b> List			Worry or Nervousness			Eating disorder anorexia or bulimia			<b>FEMALES ONLY</b>		
			Insomnia			Hernia, rupture			Excessive flow		
			Frequent Anxiety						Irregular Periods		
									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 \_\_\_\_\_