

KUMC STUDENT HEALTH SERVICES - History Record (SF)

3901 Rainbow Blvd., 1012 Student Health Center

Kansas City, KS 66160-7370

913-588-1941

CONFIDENTIALITY NOTICE

** The information contained on this health record is confidential and is intended only for the use of KUMC Student Health Services. The information will not be shared with your Academic Program unless you sign a release form.

DATE: _____

Name: _____ DOB: _____ SSN: _____
Last First MI

Address: _____ City: _____ State: _____ Zip Code: _____

Phone No. (H) (____) _____ (W) (____) _____ (Cell/Pgr.) (____) _____

E-mail Address: _____ School: SoM / SoN / Allied Health / Graduate Studies (please circle one)

Marital Status: Single Married Widowed Divorced Partnered **Citizenship:** US OTHER

Emergency Contact: Name: _____ Relationship: _____ Phone No.: (____) _____

CURRENT MEDICATIONS (Please include over-the-counter medicines, vitamins, herbals, protein supplements, etc.)

NAME OF MEDICATION	DOSAGE (mg)	FREQUENCY	REASON FOR TAKING

DRUG ALLERGIES/REACTIONS

NAME OF DRUG	REACTION

ILLNESSES (Please ✓ past and / or present)

<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Migraine Headaches
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Positive TB skin test
<input type="checkbox"/>	Cancer (type)	<input type="checkbox"/>	Sexually Transmitted Infections
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Skin Problems (type)
<input type="checkbox"/>	Depression / Anxiety	<input type="checkbox"/>	
<input type="checkbox"/>	Eating Disorders	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	G.I Problems (i.e. Gallbladder, Chrohns, Ulcers, GERD)	<input type="checkbox"/>	Urinary Infections
<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Other:
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	
<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	
<input type="checkbox"/>	Menstrual Problems	<input type="checkbox"/>	

MEDICAL HISTORY

SURGERIES, HOSPITALIZATIONS, ILLNESS, and/or INJURIES	DATES	REASON

Name: _____

WELLNESS

Check if applicable (in present or past):

YES	WOULD YOU LIKE TO CHANGE	HEALTH ISSUE	YES	WOULD YOU LIKE TO CHANGE	HEALTH ISSUE
		Drink Alcohol (How much wkly? _____)			Problems making friends or family difficulties
		Smoke (Packs per day _____) (or other tobacco products)			Concerned about exposure to AIDS or other sexually transmitted infections
		Sleep Difficulties			School concerns / difficulties
		Stress			Wear a seatbelt or motorcycle/ bike helmet
		Use illicit drugs			Other (Explain):
		Sexual concerns			
		Exercise (Times per week _____)			
		Nutrition: ___ Good ___ Bad ___ Average			
YES	NO	Have you ever been hit, slapped, kicked or otherwise physically hurt by someone?			
YES	NO	Has anyone forced you to have an unwanted sexual act?			
YES	NO	Do you do self-breast exams or self-testicular exams?			

What do you do for **FUN**? _____

Any other information you feel will be helpful to us: _____

REQUIRED PHYSICAL EXAMINATION

Physician Statement: I have examined this student and have found no evidence of abnormal findings or limitations.

Assessment Abnormalities: _____

Signature of examiner: _____

Address: _____

Please print name: _____

Phone: _____