UNIVERSITY OF HOUSTON-CLEAR LAKE HEALTH SERVICES
MEDICAL HISTORY FORM

Print Legibly

NAME_____ STUDENT ID: _____
LAST FIRST

LOCAL ADDRESS_____
Number Street Apt City State Zip Code

DAYTIME PHONE:_____ EVENING PHONE_____ UHCL Email: _____

PLACE OF BIRTH_____ DATE OF BIRTH_____ GENDER: M F

MARITAL STATUS: Married_____ Single_____ U.S. CITIZEN__ F1/J1___ PERMANENT RESIDENT___

CHECK ONE: STUDENT_____ **FACULTY/STAFF**_____ **OTHER** _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

NAME _____ RELATIONSHIP_____

ADDRESS_____ PHONE_____

2ND Emergency Contact:

NAME _____ RELATIONSHIP_____

ADDRESS_____ PHONE_____

FAMILY PHYSICIAN Name_____ Phone_____

ALLERGIES TO MEDICATION OR OTHER SUBSTANCES: YES_____ NO_____ (IF YES, FILL IN BELOW)
OTHER (SPECIFY) _____

LIST ANY MEDICATIONS THAT YOU TAKE ON A REGULAR BASIS: _____
(Including Herbal Meds)

MEDICAL HISTORY: PLEASE CHECK Yes or No

	YES	NO		YES	NO
ASTHMA			**HIGH BLOOD PRESSURE**		
CANCER			**KIDNEY DISEASE**		
HEPATITIS			**LUNG DISEASE**		
DIABETES			**SEIZURES**		
DEPRESSION			**STOMACH/GI DISEASE**		
HEART DISEASE			**SUBSTANCE ABUSE**		
ARTHRITIS			**THYROID DISEASE**		
FREQUENT HEADACHES			**URINARY TRACT INFECTION**		

OTHER_____

TOBACCO USAGE: (Circle One): NO YES
IF YES, WHAT TYPE (Cigarettes, cigars, pipe, or chewing tobacco)_____ HOW MUCH:_____

PERMANENT DISABILITIES (DESCRIBE/DATE)_____

SERIOUS ILLNESSES/INJURIES OR OPERATIONS (DESCRIBE /DATE) _____

_____

_____

IMMUNIZATIONS: Please indicate the DATE of your last immunization for Diphtheria/Tetanus_____

Preferred method of contact: Home#:_____ Work#:_____ Cell#:_____

Pager#_____ Email (specify):_____

_____ _____
Signature Date

State law requires that you be informed of the following: (1) you are entitled to request to be informed about the information about yourself collected by use of this form (with a few exceptions as provided by law); (2) you are entitled to receive and review that information; and (3) you are entitled to have the information corrected at no charge to you.