Health History

Morehead State University
(606) 783-2055

Caudill Health Clinic
150 University Blvd.
112 Allie Young Hall
Morehead, KY 40351

To be completed by patient unless under the age of 18 then must be completed and signed by parent/guardian.
Completion of this report is required before treatment at the Caudill Health Clinic at Morehead State University. All health information is confidential and will be placed on file in the Caudill Health Clinic. Please read carefully and answer all questions on both sides of the form. Consult your parents/guardian for complete and accurate information. You may need to consult your family physician or public health department for an accurate immunization record. The completed form should be returned to the Caudill Health Clinic at the address above.

Patient Information (please print in ink)

Name____
Last First Middle

Social Security Number__________________Date of Birth___/___/___ Age_____ ☐Male ☐ Female
Month Day Year

Home Address____Phone______________
Number and Street City State Zip area code

When do you plan to enroll in Morehead State University? ☐ fall________ ☐ spring________ ☐ summer________
Year Year Year

Medical History Check *yes* or *no* for each item listed and indicate *year* for each *yes* response. If any medical condition still exists for which a *yes* response was given, please give additional information on an attached sheet.

YES	NO		YEAR
		measles	
		mumps	
		chicken pox	
		mononucleosis	
		anemia or blood disease	
		heart murmur/heart disease	
		rheumatic fever	
		high blood pressure	
		clots in veins	
		gynecological problems	
		asthma	
		pneumonia	
		orthopedic injuries, fractures, surgeries	
		cancer	

YES	NO		YEAR
		tuberculosis	
		mental health care	
		meningitis	
		convulsions or seizures	
		paralysis	
		severe headaches	
		head injury with unconsciousness	
		stomach or intestinal trouble	
		ulcer	
		hepatitis (yellow jaundice)	
		gallbladder disease	
		thyroid disease	
		diabetes	
		bladder/kidney disease	

Have you had any illness, injuries, or hospitalization not already noted? ☐ yes ☐ no. If *yes,* explain on an attached sheet.

Have you ever had surgery? ☐ yes ☐ no. If *yes*, indicate date and type of operation.________________________

Are you allergic to any medications? ☐ yes ☐ no. If *yes*, indicate medication(s):

_____penicillin _____tetracycline _____sulfa _____others (specify)______________________

Are you presently taking any medication? ☐ yes ☐ no. If *yes*, list name of drug, dosage, strength, and frequency:

Do you wear contact lenses? ☐ yes ☐ no

(over)

IMMUNIZATION RECORD

Have you had the following vaccinations? If yes, please supply dates. Immunization record from health care provider can be attached.

YES	NO		Date Administered (month/day/year)
____	___	Diphtheria, Tetanus and Pertussis	#1___/___/___ #2___/___/___ #3___/___/___ #4___/___/___ #5___/___/___
____	____	Td	#1___/___/____
____	____	Oral Polio Vaccine	#1___/___/___ #2___/___/___ #3___/___/___ #4___/___/___
____	____	MMR (measles, mumps, rubella)	#1___/___/___ #2___/___/___
____	____	Chickenpox	#1___/___/___ #2___/___/___
____	____	Hepatitis B	#1___/___/___ #2___/___/___ #3___/___/___
____	____	Meningitis Vaccine	#1___/___/____

Have you had a tuberculin skin test? ☐ yes ☐ no. If *yes*, indicate date__________. Result: ☐ Pos. ☐ Neg.

If tuberculin skin test was positive, have you had a chest x-ray? ☐ yes, date:_________. Result:__________________.
☐ no

If you are an international student or have lived outside of the United States, have you received BCG? (Vaccine for Tuberculosis)
☐ yes ☐ no

Have you lived in a household with anyone who had tuberculosis? ☐ yes ☐ no. If *yes*, please explain:___________

Medical personnel of the Caudill Health Clinic will review this health history. You will be notified in writing if further medical information is needed.

Name of Personal Physician:_______________________________ Phone:_______________FAX:_______________

I certify that all information is true and correct to the best of my knowledge. I also consent to examination and treatment by Morehead State University Caudill Health Clinic staff. This consent shall be continuing until revoked in writing.

____ ____________________

SIGNATURE OF STUDENT DATE

Additional Information Person to be notified at patient request in case of illness:

____Day phone________________Evening phone_________________

Last First Area Code Area Code

Relationship to patient? ☐parent ☐ guardian ☐ spouse ☐ other____________________

Insurance Information Most services of the Caudill Health Clinic are free. Minimal fees may be charged for some lab tests and services such as allergy injections and program related physicals. Any fees charged in or outside the Caudill Health Clinic are the responsibility of the patient. We do not do third party billing***. In instances when referrals are made from the Caudill Health Clinic to specialists, private physicians, or hospitals, insurance information is often requested. Please carry a copy of your insurance card with you. It is the responsibility of the student to obtain health insurance.***

Medical Consent – *for minors only (under 18 years of age)*

I hereby consent to having qualified medical personnel render to my son or daughter medical and emergency treatment and/or surgical care, and services offered through University Counseling Center, as deemed necessary to his or her health and well being. I grant permission for the hospitalization of my son or daughter when necessary for implementing proper medical care.

I also grant permission for Morehead State University Caudill Health Clinic to use and disclose health information about my son/daughter in order to carry out treatment, payment, and health care operations as stated in Authorization and Notice of Medical Information Disclosure and Access.

____ _________________

SIGNATURE OF PARENT/GUARDIAN DATE

Revised July 2004
Form 1102