CONFIDENTIAL

MURRAY STATE UNIVERSITY
HEALTH SERVICES
HEALTH HISTORY

Date______________________________________ Social Security No. ________________________________

Name____
Last First Middle

Sex ☐ M ☐ F Date of Birth____ Age_____

FAMILY HISTORY: If any blood relative has suffered any of the following, please indicate which relative

☐ Tuberculosis ______________________
☐ Stroke______________________
☐ Migraine ______________________
☐ Heart Attack ______________________
☐ Hypertension (high blood pressure) ____________________________________

☐ Epilepsy______________________
☐ Diabetes______________________
☐ Cancer ______________________
☐ Allergy______________________

☐ Arthritis ______________________
☐ Gout______________________
☐ Kidney Disease ______________________
☐ Glaucoma______________________

PRIOR ILLNESS, OPERATION OR INJURY ____
____
____
____

MEDICATIONS - List those you are currently taking___________________________________
____

DRUG ALLERGIES - List those you are allergic to ____________________________________
____
____

MEDICAL HISTORY - Check where applicable

☐ Decreased hearing
☐ Ringing in ear
☐ Ear infections - frequent
☐ Double or blurred vision
☐ Eye infections - frequent
☐ Nose Bleeds - recurrent
☐ Sinus trouble
☐ Sore throats - frequent
☐ Hay fever/allergies
☐ Pneumonia/pleurisy
☐ Bronchitis/chronic cough
☐ Asthma/wheezing
☐ Chest pain
☐ High blood pressure
☐ Fainting spells
☐ Loss of appetite - recent
☐ Persistent nausea/vomiting
☐ Peptic Ulcers
☐ Cancer
☐ Muscle weakness
☐ Numbness/tingling sensation
☐ Back pain - recurrent
☐ Eczema

☐ Change in bowel habits - recent
☐ Diarrhea ☐ Constipation
☐ Hemorrhoids
☐ Gall bladder trouble
☐ Jaundice/hepatitis
☐ Hernia
☐ Urine infections - frequent
☐ Painful urination
☐ Blood in urine
☐ Kidney stones
☐ Sexually Transmitted Disease
☐ Urethral discharge
☐ Chronic fatigue
☐ Weight loss - recent
☐ Anemia ☐ Bruise easily
☐ Diabetes
☐ Thyroid disease
☐ Convulsions/seizures/epilepsy
☐ Stroke
☐ Headaches
☐ Arthritis/rheumatism
☐ Gout
☐ Foot pain
Prosthesis ______________________

☐ Cold, numb feet
☐ Rashes
☐ Hives
☐ Depression
☐ Heart Murmur
☐ Chicken Pox
☐ Polio
☐ Measles
☐ German measles
☐ Rheumatic fever
☐ Scarlet fever
☐ Mumps
☐ Tuberculosis
☐ Tobacco use
Type ______________________
Amount per day ______________________
☐ Caffeine beverages
Cups per day ______________________
☐ Alcohol
oz. per week ______________________
☐ Street Drug use ______________________
☐ Height ______________________
☐ Weight ______________________

Additional comments ____
____
____

Please complete both sides of this form and return to: Murray State University, Health Services
136 Wells Hall, Murray KY 42071-3318. (270) 809-3809

IMMUNIZATION RECORD

Name ____

Last First Middle

Date ____________ **Date of Birth** _____/_____/______ **Social Security Number**____________________________

You may attach a copy of your immunization record.

A. **Tetanus-Diphtheria** (need booster every ten years) Date of last booster _____/_____ Mo Yr

B. **Measles, Mumps, Rubella (M.M.R.)** (two doses required) 1. ______/______ Mo Yr 2.______/_____ Mo Yr

C. **Tuberculosis (PPD)**

1. PPD (Mantoux) Results: Neg _____ Pos _____ mm induration _____ ______/_____ Mo Yr

2. If Positive - chest x-ray X-ray result: Normal _____ Abnormal _____

D. **Polio**

1. Completed primary series of polio immunization: Yes ___ No___ Date of last booster _____/_____ Mo Yr

E. **Hepatitis B** (Optional)

1. Dose #1 ______/______ Mo Yr Dose #2 ______/______ Mo Yr Dose #3 _____/_____ Mo Yr

F. **Varicella -** Immunization 1. ______/______ Mo Yr 2. _____/_____ Mo Yr

Had chicken pox Yes ___ No ____

G. **Bacterial Meningitis** (Optional) Immunization _____/_____ Mo Yr

Health Care Provider

Name ____________________________________ Address ______________________________________

Signature __________________________________ Phone (________)________________________________