CONFIDENTIAL

MURRAY STATE UNIVERSITY
HEALTH SERVICES
HEALTH HISTORY

DATE_______________________________________ M#______________________________

NAME ____

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 _____________

COMMENTS: ____

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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
☐ Emphysema
☐ Chest pain
☐ High blood pressure
☐ Congestive heart failure
☐ Heart attack
☐ Fainting spells
☐ Loss of appetite – recent
☐ Persistent nausea/vomiting
☐ Peptic Ulcers
☐ Cancer
☐ Muscle weakness
☐ Numbness/tingling sensation
☐ Back pain – recurrent

☐ 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 Infections
☐ Urethral discharge
☐ Chronic fatigue
☐ Weight loss – recent
☐ Anemia ☐ Bruise easily
☐ Diabetes
☐Thyroid disease
☐ Convulsions/seizures/epilepsy
☐ Stroke
☐ Headaches
☐ Arthritis/rheumatism
☐ Gout
☐ Foot pain
Prosthesis ________________
☐ Fibromyalgia

☐ Cold, numb feet
☐ Rashes
☐ Eczema
☐ Hives
☐ Depression
☐ Heart murmur
☐ Chicken pox
☐ Polio
☐ Measles
☐ German measles
☐ Rheumatic fever
☐ Scarlet fever
☐ Mumps
☐ Tuberculosis
☐ Tobacco use
Type________________
Amount/day ___________
☐ Caffeine beverages
Cups per day __________
☐ Alcohol
oz. / week____________
☐ Street drug use__________
☐ Height________________
☐ Weight ______________
☐ BMI ________________

Additional comments: ____

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Please complete both sides of this form and return to: Murray State University Health Services, 136 Wells Hall, Murray, KY 42071-3318. Phone: (270) 809-3809 Fax: (270) 809-3540

Please explain prior illnesses, hospitalizations, injuries, and surgeries with detail and dates.

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Please list **all** medications, including vitamins, herbal or natural supplements and prescription medications, which you are currently taking. Please note dosage and how long you have taken the medication.

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Please list any medication allergies you have and the reaction the medication caused.

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Please provide names and phone numbers of doctors, chiropractors or other health care professionals you are receiving care from.

Provider:	Condition they are treating you for:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

IMMUNIZATION HISTORY

Tetanus (booster needed every 10 years) date of last booster ______________________

Tuberculosis (PPD) Results: Neg ____ Pos ______ mm induration _______ date ___________

If positive, chest x-ray result ____