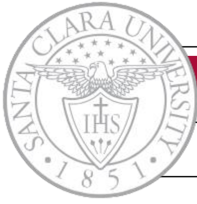

Santa Clara University

The Cowell Center

Medical History

Student Health Center

RN	MD	PPD	Receipt
			Entered/Medpro

Santa Clara University Cowell Center, Student Health Center requests this confidential information for the purpose of providing patient care. Persons outside the Student Health Center are not routinely provided this information without the patient's knowledge and written consent. Responses to all items are required in order to facilitate appropriate patient care.

A. Personal Data

Last Name ______ First Name ______ Middle Name ______ Date of Birth ______ Student ID # ______

Height ______ Weight ______ Cell Phone or Local Phone Number ______ Email Address ______

Permanent Address ______ City ______ State ______ Zip Code ______ Home Phone ______ Work Phone ______

Contact Person/Relationship ______ Home Phone ______ Work Phone ______

B. Personal Medical History

Have you had any of the following?

	Yes	No		Yes	No		Yes	No
Allergies/Hay Fever			Eating Disorder			Rheumatic Fever		
Anxiety			Eye Trouble			Seizure Disorder		
Asthma			For Females: Menstrual Irregularity			Sexually Transmitted Disease		
Back Problems			Genetic Disorder			Stomach or Intestinal Problems		
Bleeding Disorder			Heart Problems			Thyroid Problems		
Depression			Head Injury			Tuberculosis		
Diabetes			High Blood Pressure			Tumor or Cancer		
Disease or Injury of Joints			High Cholesterol (specify results)			Weakness or Paralysis		
Ear, Nose, Throat Problems			Liver or Kidney Problems			Other:		

For items marked "yes", please explain: (For additional space, see reverse side)

____

____

____

____

Have you ever been hospitalized? _________ (Date/Explanation) ______________________________

____

Have you ever had surgery? __________ For what/when?______________________________

____

List any medications you currently take: (Include over the counter medicines, contraceptives, herbal drugs, or supplements.)

Medication Name	Dosage	Frequency	Reason

*******List any allergies to: *******

Medications (list type of reaction you had): ______________________________

____

Food or environmental allergies: ______________________________

____

Please continue on the reverse side

2013/2014

C. Family History

Check if you are adopted: ☐

1) Background about your immediate family:

	Age	Occupation	Health problems? / Take medications for?		Age	Any health problems
Father				Brother		
Mother				Sister		

2) Have any of your relatives had the following (state relationship to you):

	Yes	No	Relationship		Yes	No	Relationship
Alcohol/Drug Issues				High Cholesterol			
Bleeding Disorder				Kidney Disease			
Cancer (Type)				Psychological Disorder			
Death Before Age 50				Rheumatoid Arthritis			
Diabetes				Seizures/Epilepsy			
Heart Disease/Stroke				Thyroid Problem			
Hereditary Disease				Tuberculosis			
High Blood Pressure				Other:			

Additional Explanation:

____

____

____

____

____

____

____

____

____

____

X ____

Patient Signature Date

REVIEWED: ________________________

MD/NP/PA Initials Date

Annual Updates:

Updated: ____________ ____________

Initials Date

Updated: ____________ ____________

Initials Date

Updated: ____________ ____________

Initials Date