

WE DO NOT ACCEPT MEDICAID

**USM STUDENT HEALTH SERVICE
INITIAL HEALTH HISTORY**

Name _____ SSN _____
(Last) (First)

Nickname? _____ ID # _____
Male ___ Female ___

Date of birth _____ Phone _____ Cell phone _____

(School or Local)

Address _____ Email address _____
Street or P.O.

_____ *City* _____ *State* _____ *Zip*

(Home)

Permanent address _____

_____ *City* _____ *State* _____ *Zip*

Please give us information on two contact persons in case of emergency:

_____ *Name* _____ *Phone #* _____ *Relationship*

_____ *Name* _____ *Phone #* _____ *Relationship*

Health Insurance **Yes No** Name of Company _____

Are you an organ donor? **Yes No** Do you have a living will? **Yes No**

Do you have any drug allergies? _____

What surgeries have you had? _____

Are you willing for USM Student Health Service to treat you? Please sign below:

CONSENT FOR TREATMENT _____

For faculty/staff who have *Blue Cross/ Blue Shield of Mississippi*:

If you have this insurance, and want us to file, please sign: _____

You must also fill out a medical claim form and present your insurance card.

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

Please list medications you take regularly, including *birth control pills, over-the-counter, or herbal medicines:*

Have <u>you</u> ever had:	Yes	No	Medication?	Has your <u>family</u> had:	Yes	No	Relationship
ADD/ ADHD				ADD/ ADHD			
Allergies				Allergies			
Anemia				Anemia			
Anxiety				Anxiety			
Asthma				Asthma			
Arthritis				Arthritis			
Blood clots				Blood clots			
Cancer (type)				Cancer (type)			
Depression				Depression			
Diabetes				Diabetes			
Epilepsy/ seizures				Epilepsy/ seizures			
Heart disease				Heart disease			
Hepatitis				Hepatitis			
High blood pressure				High blood pressure			
HIV/ STD				HIV/ STD			
Kidney/ urinary problems				Kidney/ urinary problems			
Menstrual cramps				Menstrual cramps			
Migraines				Migraines			
Sickle cell				Sickle cell			
Stomach problems				Stomach problems			
Stroke				Stroke			
Thyroid problems				Thyroid problems			
Tuberculosis				Tuberculosis			
Other				Other			

Tobacco use? Yes No Alcohol use? Yes No Use other drugs? Yes No

Your height: _____

Your race: _____

Reviewed by: _____
MD/NP

Date: _____