

Student Health Form

GENERA	LINF	ORMATION		
Name:			Birthdate:/ /	
Home Addres	SS:	ber and street, P.O. box or apt. # city state	Phone Number: ()	
		Female T#:	1	
			Phone Number ()	
	d any of t	HISTORY the following conditions or related conditions? If "yes," please describe. List frequency Respiratory System: hay fever, asthma, tuberculosis, sinus problems?		
Yes	No	Cardiovascular: palpitations, high/low blood pressure, chest pain, heart murmur, hea	rt disease?	
Yes _	No	Blood Disease Disorders: anemia, bleeding tendencies?		
Yes _	No	Muscle-Skeletal: "trick" knee, back problems, broken bones, recurrent sprains/tendonitis, deformities, arthritis?		
Yes	No	Endocrine: thyroid, diabetes, adrenal?		
Yes	No	Gastrointestinal: ulcer, gallbladder, diarrhea, constipation?		
Yes	No	Genitourinary: menstrual problem, kidney/bladder problems, prostatitis, vaginal infections?		
Yes	No	Neurological: seizures, hearing problems, head injury with unconsciousness?		
Yes	No	Psychological: anxiety, depression, other emotional disorders?		
Yes	No	Infections: rheumatic fever, malaria, hepatitis?		
Yes	No	Surgeries: tonsillectomy, appendectomy, hernia repair, other?		
Yes	No	Tumor/cyst/cancer?		
		CAL HISTORY Allergies: medicines, bee stings, other? If "yes", please list:		
Yes	No	Are you currently taking any prescribed drugs or medical treatment (including birth control pills)?		
Yes _	No	Do you know any reasons why you should not participate in normal physical exercise?		
Yes _	No	Do you have any questions regarding your health or other matters you'd like to discuss with the Health Services staff?		
PERMISSI	ON FO	R TREATMENT AT TTU STUDENT HEALTH SERVICES (if under 18,	co-signed by parent or guardian)	
Student signa	ture:		Date:	
Parent/Guard	lian siana	ture (If student is under 18):	Date:	