Medical History (Confidential)
Completion of this form is REQUIRED prior to
Receiving non-emergency care.

Return completed form to: MSSU Health Center
3950 E. Neman Road
Joplin, MO 64801

Name: ____ Sex: M F Age: _______ Date of *Birth:* __ /__/_
Last First Middle mm/dd/yy

Local Address: ____ Telephone: ____________________
Street City State Zip

Marital Status: Single /Married/ Widowed/ Divorced Race: ________________________

Name of Nearest Relative:____ Relationship: ________________________

Address of Nearest Relative:____ Telephone: __________________
Street City State Zip

Family or Primary Physician: ___________________________Address: ____

Phone numbers where parents can be reached in an emergency: ____

I will enter MSSU: ______________________ ________ Classification: Fr/ Soph/ Jr/ Sr/ Employee/ Other
Semester/year

Have you ever had or do you have now a problem with:

__Alcohol
__ Anemia
__ Arthritis
__ Asthma
__Back Problems
__ Cancer
__Chicken Pox
__Colitis
__ Convulsions/Seizures
__Cough (Chronic)
__ Depression
__Diabetes
__ Disability/Handicapped

__ Drug Abuse
__ Ear Trouble /Hearing Loss
__ Eating Disorder
__ Eye Disease/Problems
__ Gallbladder Trouble
__ Hay Fever (Recurrent)
__ Head Injury
__ Headache (Recurrent)
__ Heart Disease/Problem
__Hepatitis/Jaundice
__Hernia /Rupture
__ High Blood Pressure
__ intestinal/stomach Trouble

__ Joint Disease/Injury
__ Measles, Red
__ Migraine Headaches
___Mononucleosis, Infectious
__ Mumps
___Paralysis
__ Pneumonia
__ Polio
___Psychological Counseling
__ Rheumatic Fever
__ Rubella (3 Day Measles)
__ Scarlet Fever
__ Sexually Transmitted Disease (STD

__Sickle Cell Trait/Anemia
__ Sinus Trouble
__ Skin Problems (Chronic)
__ Sleep Problems
__Smoking (How long?)
___Suicide Attempt
__ Surgery
__ Thyroid Disease
__ Tuberculosis
__ Urinary Tract Infection
__ Other

If none of the above applies, check here: _________
Describe answers above with dates: ____
If none of the above applies, check here: _________
Describe answers above with dates: ____

List Drug Allergies:
____
____
____
____
____

If not known, check here_____

Date of last Physical Exam: ________________

Height:________________
Weight:________________

While at MSSU will you need Allergy Shots?________________

(If “yes” bring written instructions from your physician)

List Current Medications:
____
____
____
____
____
____
____

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Please attach a copy of your Immunization Record!

Proof of MMRII is REQUIRED! Date of MMRII (If already rec'd) ____________________

MMRII is available at the MSSU Health Center free of charge.

STUDENTS LIVING IN RESIDENCE HALLS ARE REQUIRED, BY LAW, TO HAVE A MENINGITIS VACCINE, OR SIGN A WAIVER REFUSING IT!

Meningitis is an infection that is rapidly progressive and may be mistaken for Influenza. It can progress from flu-like symptoms to death within 24 to 48 hours. College freshmen living in residence halls are at a 6-fold higher risk for meningitis compared with other college students. (See the attached waiver for more information)

The Meningitis vaccine is available at the MSSU Health Center at cost.

TO PARENTS OF STUDENTS UNDER AGE 18: I hereby grant permission to the medical staff of the MSSU Health Center to carry out necessary medical treatment of the above patient.

____

Signature of Parent/Guardian Date

BILLING POLICY:

While office visits are free, some services have fees. Students may pay charges at the time of service, or can be billed by Student Accounts, payable within 30 days. FACULTY/STAFF CHARGES ARE DUE AT THE TIME OF SERVICE!

Name (print),____ ______________ ____________

Last First Middle Social Security Number Date

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Family History

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Sisters				
Brothers				

Has any relative (father, mother, sister, brother, or grandparents) suffered from the following?

	Yes	NO	Relationship
Arthritis			
Asthma			
Cancer (what type?)			
Diabetes			
Epilepsy/Seizures			
Heart Attack (before age of 50)			
High Blood Fat Levels			
High Blood Pressure			
Kidney Disease			
Mental Disease / Disorder			
Migraine Headaches			
Sickle Cell Trait/ Disease			
Stomach/ Colon Problems			
Thyroid Disease			
Tuberculosis			
Other			

Any other information which could be helpful in your care at MSSU Health Center?

____

____

For Females Only:

Age of first menstrual period:________________ Menstrual irregularities? Yes/No_____

How many pregnancies? _________________

I hereby certify that the above history is complete to the best of my knowledge.

____

Name Date Social Security Number