The information on this form is confidential and will not be released outside of the Health Services Clinic without written authorization from the student.

NAME: _____ SEX :MALE ___ FEMALE _____

BIRTH DATE __/___/___ STATE/COUNTRY OF BIRTH _____/_____

PERMANENT ADDRESS _____

CITY _____ _____ ZIP CODE _____

PREFFERRED PHONE FOR STUDENT (___) _____

STUDENT'S EMAIL _____

PARENT, GUARDIAN, OR EMERGENCY CONTACT

NAME _____ PHONE (___) _____

ADDRESS (if different from above address) _____

PERSONAL PHYSICIAN

NAME _____ PHONE (____) _____

ADDRESS _____

1) Allergic to the following medications _____
2) Other allergies _____
3) Current medications with dosages (including "as needed" medications) Please include herbs, vitamins, supplements

   _____

   _____

   _____
4) Surgeries and hospitalizations

   _____
5) Do you have a disability or special need? _____
6) Other health information

   _____

   _____

If student is a minor and under 18 years of age, he/she cannot be treated at the Health Services Clinic without parental consent. Under an exception to Ohio law, minors can be seen for contraception and sexually transmitted disease treatment without parental consent. If the student is under 18, and an emancipated minor, proof of emancipated status should be attached.

Return completed form to:
Miami Health Services Clinic
Fax: 513 529 1892 or
Email: shs@miamioh.edu

STUDENT'S PERSONAL HEALTH HISTORY	yes	no	details, if needed
severe acne	○	○	
alcohol or chemical dependency	○	○	
anemia or other blood disorder	○	○	
asthma or other lung disease	○	○	
attention deficit disorder	○	○	
bone or joint injury or disease	○	○	
cancer	○	○	
chickenpox	○	○	
concussion or head injury	○	○	
depression and/or anxiety	○	○	
diabetes	○	○	
loss of consciousness or fainting	○	○	
ear disease or hearing loss	○	○	
eating disorder	○	○	
eye disease or blindness	○	○	
headaches	○	○	
heart disease	○	○	
hepatitis	○	○	
hernia	○	○	
high blood pressure	○	○	
kidney or urologic disorder	○	○	
major trauma	○	○	
meningitis	○	○	
menstrual problems	○	○	
mononucleosis	○	○	
obesity	○	○	
pregnancy	○	○	
Mental health or behavioral disorders	○	○	
recurrent tonsillitis	○	○	
seizures	○	○	
sexually transmitted infections	○	○	
sickle cell trait or disease	○	○	
suicide attempt	○	○	
thyroid disorder	○	○	
transfusion	○	○	
other serious or chronic health condition not listed	○	○	

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FAMILY HISTORY

Please designate:
M = mother, F = father, S = sibling
MGM= maternal grandmother, MGF=maternal grandfather
PGM=paternal grandmother, and PGF=paternal grandfather

	M	F	S	MGM	MGF	PGM	PGF
asthma or other lung disease	☐	☐	☐	☐	☐	☐	☐
blood clots or other blood disorder	☐	☐	☐	☐	☐	☐	☐
cancer	☐	☐	☐	☐	☐	☐	☐
diabetes	☐	☐	☐	☐	☐	☐	☐
heart disease	☐	☐	☐	☐	☐	☐	☐
high blood pressure	☐	☐	☐	☐	☐	☐	☐
high cholesterol	☐	☐	☐	☐	☐	☐	☐
mental health disorders	☐	☐	☐	☐	☐	☐	☐
migraines	☐	☐	☐	☐	☐	☐	☐
stroke	☐	☐	☐	☐	☐	☐	☐
sudden death under age 50	☐	☐	☐	☐	☐	☐	☐
Suicide	☐	☐	☐	☐	☐	☐	☐
tuberculosis	☐	☐	☐	☐	☐	☐	☐
other significant health problem	☐	☐	☐	☐	☐	☐	☐

The information on this form is true to the best of my knowledge. Parents need only sign if student is under the age of 18.

Student signature _____ date _____

Parent signature (if applicable) _____ date _____

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