

Student Health Center  
 Box 30001, MSC 3529  
 Las Cruces, NM 88003-8001  
 (505) 646-1512



This form is to be filled out by the student using family health records and should be returned by mail to the Student Health Center at the address to the left. After the initial Student Health Center visit, students will need the form completed before continued care is provided.

# MEDICAL HISTORY

Name \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_ Date \_\_\_\_\_  
 Birth Date \_\_\_\_\_ Birth Place \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Next of Kin Name \_\_\_\_\_ Address \_\_\_\_\_ Phone Number \_\_\_\_\_

**PERMISSION TO TREAT MINOR:** Parent or legal guardian:  
 You must complete the following if the student is not yet 18 years old.  
 I give all practitioners at the Student Health Center of New Mexico State University my permission to treat the student named at right.

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Signature of Parent or Legal Guardian

**FAMILY HISTORY**

Father's Name \_\_\_\_\_  
 Father's Age \_\_\_\_\_ Health \_\_\_\_\_  
 If deceased, cause and age \_\_\_\_\_  
 Mother's Name \_\_\_\_\_  
 Mother's Age \_\_\_\_\_  
 If deceased, cause and age \_\_\_\_\_

**HAS ANY BLOOD RELATIVE EVER HAD:**  
 (\*X\* the yes answers and give relationship)

High Cholesterol \_\_\_\_\_  
 Cancer \_\_\_\_\_  
 Tuberculosis \_\_\_\_\_  
 Diabetes \_\_\_\_\_  
 Heart Trouble \_\_\_\_\_  
 High Blood Pressure \_\_\_\_\_  
 Stroke \_\_\_\_\_  
 Alcoholism \_\_\_\_\_  
 Psychological disorder \_\_\_\_\_  
 Other \_\_\_\_\_

**FOR WOMEN - MENSTRUAL HISTORY**

Age of menstruation onset: \_\_\_\_\_  
 Regular?  Yes  No Every \_\_\_\_ days

Number of:   Pregnancies   \_\_\_\_\_  
                   Live births       \_\_\_\_\_  
                   Miscarriages   \_\_\_\_\_  
                   Abortions       \_\_\_\_\_

**ALLERGIES**

Medications: \_\_\_\_\_  
 Food Products (such as eggs, other): \_\_\_\_\_  
 Insect bites: \_\_\_\_\_  
 Other: \_\_\_\_\_

**CHRONIC MEDICAL CONDITIONS**  
 (Please List)

**SPECIAL PROCEDURES (When)**

EKG (Electrocardiogram) . . . . . \_\_\_\_\_  
 EEG (Electroencephalogram) . . . . . \_\_\_\_\_  
 Ultrasound . . . . . \_\_\_\_\_  
 CAT Scan . . . . . \_\_\_\_\_  
 Bone Scan . . . . . \_\_\_\_\_  
 MRI . . . . . \_\_\_\_\_  
 Mammography . . . . . \_\_\_\_\_  
 Other . . . . . \_\_\_\_\_

**SURGERY (When)**

Tonsillectomy \_\_\_\_\_  
 Appendectomy \_\_\_\_\_  
 Any other (what) \_\_\_\_\_

Have you ever been advised to have any surgery which has not been done? \_\_\_\_\_

**SERIOUS INJURY**

Give dates, explain: \_\_\_\_\_

**HOSPITALIZATIONS (When)**

Have you been hospitalized for any illness?  
 Give details: \_\_\_\_\_

**REGULARLY USED MEDICATIONS**  
 (Include medications for allergies, birth control, OTC, etc)

**IMMUNIZATIONS**   Give latest date

Tetanus/Diphtheria . . . . . \_\_\_\_\_  
 Menomune . . . . . \_\_\_\_\_  
 Pertussis . . . . . \_\_\_\_\_  
 Polio . . . . . \_\_\_\_\_  
 Measles . . . . . \_\_\_\_\_  
 Rubella (German Measles) . . . . . \_\_\_\_\_  
 Mumps . . . . . \_\_\_\_\_  
 Hepatitis A . . . . . \_\_\_\_\_  
 Hepatitis B . . . . . \_\_\_\_\_  
 BCG (for tuberculosis) . . . . . \_\_\_\_\_  
 Varicella . . . . . \_\_\_\_\_  
 Other . . . . . \_\_\_\_\_  
 TB Skin Test - Date \_\_\_\_\_ Result \_\_\_\_\_

**DRUG USE**

Tobacco:   Type \_\_\_\_\_  
                   Amount \_\_\_\_\_  
                   Duration (years) \_\_\_\_\_

Alcohol:   Average cans of beer or equivalent  
                   per week \_\_\_\_\_

Recreational Drugs: (List and amount)  
 \_\_\_\_\_

**PERSONAL HISTORY — Illnesses: "X" Yes Answers Only**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Ulcer  | <input type="checkbox"/> Eating Disorder            |
| <input type="checkbox"/> Migraine Headaches      | <input type="checkbox"/> Bowel Disease                                  | <input type="checkbox"/> Serious Depression/Anxiety |
| <input type="checkbox"/> Thyroid problems        | <input type="checkbox"/> Kidney Disease                                 | <input type="checkbox"/> Alcoholism                 |
| <input type="checkbox"/> Pneumonia               | <input type="checkbox"/> Frequent bladder infections (more than 4/year) | <input type="checkbox"/> Drug Dependence            |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Sexually transmitted disease                   | <input type="checkbox"/> Measles                    |
| <input type="checkbox"/> Tuberculosis            | <input type="checkbox"/> Arthritis                                      | <input type="checkbox"/> Mumps                      |
| <input type="checkbox"/> Rheumatic fever         | <input type="checkbox"/> Bone or joint disease                          | <input type="checkbox"/> Chicken Pox                |
| <input type="checkbox"/> Rheumatic heart disease | <input type="checkbox"/> Neurologic/Nerve problem                       | <input type="checkbox"/> Whooping Cough             |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Diabetes                                       | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Cancer   | <input type="checkbox"/> Diphtheria                 |
| <input type="checkbox"/> Liver problem/Hepatitis | <input type="checkbox"/> Abnormal Pap Smear                             | <input type="checkbox"/> Polio                      |
| <input type="checkbox"/> Gallbladder disease     | <input type="checkbox"/> Hay Fever/Allergies                            | <input type="checkbox"/> Other _____                |

**HEALTH MAINTENANCE**

Do you always wear a seat belt in a car?  Yes  No

If you ride a bicycle or motorcycle, do you wear a helmet?  Yes  No

Do you exercise regularly?  Yes  No

Describe:

Do you know your cholesterol level? If yes, what is it? \_\_\_\_\_  Yes  No

Are there smoke detectors where you live?  Yes  No

Do you use sun screen?  Yes  No

If you are sexually active, do you always protect yourself against sexually transmitted disease?  Yes  No

If you are sexually active, do you use contraception (condoms, pill, diaphragm, etc.)?  Yes  No

Have you ever been sexually, physically, or emotionally abused?  Yes  No

Are you satisfied with your present weight?  Yes  No

Females: Do you get a yearly Pap test?  Yes  No

Do you do breast self exam?  Yes  No

Males: Do you do testicular self exam?  Yes  No

Other information which may be helpful in your care:

Initial Visit:

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

OPTIONAL REVIEW (Date & initial any changes):

Student Signature \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_