HEALTH RECORD

:ASE ANSWER ALL QUESTIONS. Type or print answers. This information is confidential and will not be released without your written consen
urn this form to: *University of the Incarnate Word, Health Services, 4301 Broadway, San Antonio, Texas 78209, Phone (210) 829-6017.*

OFFICE USE ONLY

ate Received _____
ealth Record ❑
mmunizations ❑
surance Card ❑

CLASSIFICATION

ate Enrolled _____
rst Year ❑
ophomore ❑
nior ❑
enior ❑
raduate ❑
ansfer ❑
ternational ❑

NAME: _____
Last First Middle

Social Security No. _____ Date Of Birth _____ Gender _____ Marital _____

Home Address _____

City _____ State _____ Zip _____

Phone No. _____ Citizenship _____ Are you a Military Dependent? _____

PARENT, GUARDIAN OR SPOUSE (please circle)

_____
Last First Middle

Home Address _____

City _____ State _____ Zip _____

Phone No. _____
(Daytime) (Evening)

AMILY HISTORY

ather Living Deceased
Age at Death _____
Cause of Death _____
Occupation _____

lother Living Deceased
Age at Death _____
Cause of Death _____
Occupation _____

iblings Number Living ____ Number Deceased ____
Age at Death _____
Cause of Death _____

Have any of your relatives had any of the following?

	Circle Yes or No	Relationship (if yes)
No	Arthritis	Yes _____
No	Asthma	Yes _____
No	Heart Disease	Yes _____
No	Cancer	Yes _____
No	Diabetes	Yes _____
No	Kidney Disease	Yes _____
No	Seizure Disorder	Yes _____
No	Emotional Illness	Yes _____
No	Tuberculosis	Yes _____
No	Other: Specify	Yes _____

:sonal Medical History: Have You Or Do You Have:

Asthma
Cancer
Diabetes
Chronic Cough
Tuberculosis
Heart Disease
Kidney/Bladder Disease
Bone Joint Disease
Sexually Transmitted Disease
Seizures/Blackouts
Anxiety/Depression
Head Injury
Recurrent Headaches
Hi/Low Blood Pressure
Gum/Dental Disorder

❑ Peptic Ulcer
❑ Eating Disorder
❑ Chicken Pox
❑ Bleeding Disorder
❑ Hepatitis/Jaundice
❑ Recent Weight Change
❑ Infectious Mononucleosis
❑ Psychiatric Treatment
❑ Wear Contact Lenses
❑ Wear Hearing Aid
❑ Other Handicaps/Needs
❑ Tonsillectomy
❑ Appendectomy
❑ Hernia Repair
❑ Other Operations

❑ Female Menstrual Problems
❑ Scarlet Fever
❑ German Measles (Rubella)
❑ Measles (Rubella)
❑ Mumps
❑ Malaria

ALLERGIES

❑ Penicillin
❑ Sulfa
❑ Codeine
❑ Aspirin
❑ Foods
❑ Seasonal Pollen
❑ Wasp/Bee Stings
❑ Other:

ease Comment On Any Checked Boxes: (Include Explanation and Dates of Illness) _____

STATEMENT OF AUTHORIZATION

ıthorize the Student Health Service at the University of the Incarnate Word to administer medical services, and to perform routine and emergency diagnostic a
rapeutic procedures as deemed necessary by duly licensed medical personnel.

dent Signature Date