Texas State University-San Marcos
Student Health Center, 601 University Dr., San Marcos, TX 78666

REPORT OF MEDICAL HISTORY

Last Name___________________________First Name_______________________MI____Date_____________

PLID_______________________ Sex (circle): F M Date of Birth_______________________Age_______

Local Address_________________________________City_____________________State_____Zip__________

Phone # Home:( )____________Cell:( )________________E-mail address_________________________

FAMILY HISTORY

Please provide information about your father, mother, and sibling(s) only.

Disease/Condition	Family Member(s)	Disease/Condition	Family Member(s)
Alcoholism		High Blood Pressure	
Arthritis		High Cholesterol	
Asthma or Allergies		Migraines	
Cancer, specify		Thyroid problems	
		Tuberculosis	
Depression/Anxiety		Other:	
Diabetes		If deceased, age and cause of death	
Heart Disease			

PERSONAL MEDICAL HISTORY

Please provide information about yourself

Any drug allergies?
____None
____Yes, please list:

Allergies to materials, foods, other?
____None
____Yes, please list:

List any medications, vitamins or supplements that you routinely take: ____None

Please list any surgeries or hospitalizations and indicate the year it occurred. ______None

Have you had any of the following?

Condition			Condition		
Asthma or hayfever	Yes	No	Liver Disease	Yes	No
Depression or Anxiety	Yes	No	Seizures	Yes	No
Diabetes	Yes	No	Sexually Transmitted Infection	Yes	No
Digestive Illness/Ulcers	Yes	No	Thyroid Problem	Yes	No
Headaches/Migraines	Yes	No	Vision/Eye Problems	Yes	No
Heart Disease	Yes	No	Other	Yes	No
High Blood Pressure	Yes	No	please explain: ______________________________		
High Cholesterol	Yes	No	Cancer	Yes	No
Joint or Muscle Problem	Yes	No	If yes, please specify___________________________		

Men's Health: Testicular Problems? No Yes, explain:

Women's Health:

Breast problems? Yes No
Severe menstrual cramps? Yes No
Pelvic infection? Yes No
Irregular periods? Yes No
How long?___________________________

Age at first period:_____________________
Number of pregnancies:________________
Number of living children:_______________
Date of last Pap?________ Result? normal abnormal
History of abnormal Paps? Yes No

I certify to the best of my knowledge that the information on this form is true and accurate.

Date

Signature of student. (Signature of parent or legal guardian if student is less than 18 years of age.)

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Note: Information on this page will not be released routinely. Specific authorization from you is required to do so.

Last Name ________________________ **DOB** ________________

Emergency Contact Information

Name of contact and relationship: ________________________________

Address:____________________City:______________State:_____Zip:________

Home phone # ( )____________________Work phone# ( )________________

PREVENTIVE HEALTH

This information is CONFIDENTIAL and for SHC use only. We will not release without specific consent from you.

Do you use tobacco? No Yes_______cig/pks per week	Do you consistently wear a seat belt? No Yes
Average alcohol intake per week?___________ N/A	Have you had the Hepatitis B vaccine? No Yes
Have you ever had a DUI? No Yes when?____________	If sexually active, do you consistently use condoms? No Yes N/A
How often do you exercise? Less or More than 3x/week	
Have you ever used illegal drugs? No Yes	Would you like information about birth control or sexually transmitted diseases? No Yes

CONSENT TO TREATMENT

Consent must be signed prior to receiving services.

I authorize the Student Health Center to administer medical and surgical services and to perform routine and emergency diagnostic and therapeutic procedures as deemed necessary by duly licensed medical personnel.

Signature of student	Date	Signature of Parent or Guardian if student is less than 18 years of age.	Date

AGREEMENTS

FINANCIAL:

The cost of services provided by the Student Health Center (SHC) is the responsibility of the student, parent, or guardian. Registered students who have paid the Medical Service Fee are entitled to access services at the SHC. However, there is a charge for lab tests, x-rays, treatments, medications, supplies, services, and Preferred Provider Network referrals. Payment is required at the time medical services are rendered by either cash, check, Visa, MasterCard, or American Express credit cards. Visa and MasterCard debit cards are also accepted. A Walk-Out Statement outlining services rendered and diagnosis and procedure codes assigned is provided with each patient visit, which may be used in filing for reimbursement with your insurance company. Having optional student insurance coverage or coverage through a private insurance company does not relieve you of your financial responsibility.

INSURANCE CLAIMS and ASSIGNMENT OF BENEFITS:

I authorize the SHC to use and disclose my health information for processing of insurance claims for Texas State Workers' Comp or student insurance plan benefits. I authorize payment of my medical benefits be made to the SHC.

ELIGIBILITY:

The Student Health Center provides services only to those individuals who meet the SHC eligibility policy. Individuals eligible to access services are registered students and non-registered students for *only one semester after last enrolled*. Others who are eligible to use the SHC on a limited basis are participants of a university function, university employees with work-related injuries, and faculty and staff for certain services.

Please sign below to indicate you have read, understand, and agree to the above conditions.

Signature of student	Date	Signature of Parent or Guardian if student is less than 18 years of age.	Date

Reviewed by____________________**Date**____________