MSU TEXAS
MIDWESTERN STATE UNIVERSITY

MEDICAL HISTORY

Vinson Health Center

LAST NAME (PRINT) FIRST MIDDLE MUSTANGS ID NUMBER

ADDRESS (NUMBER/ APT # AND STREET) CITY STATE ZIP CODE

LOCAL CELL PHONE NUMBER LOCAL PHONE NUMBER DATE OF BIRTH SEX/ETHNICITY

YOUR PREFERRED EMAIL ADDRESS

IN CASE OF EMERGENCY (USA ONLY) RELATIONSHIP HOME/CELL NUMBER (USA ONLY)

IN CASE OF EMERGENCY ADDRESS (NUMBER, STREET, APT.) CITY STATE ZIP CODE

Have any of your relatives ever had any of the following?

	Yes	No	Relationship		Yes	No	Relationship
Tuberculosis				Arthritis			
Diabetes				Stomach Disease			
Kidney Disease				Asthma, Hay Fever			
Heart Disease				Epilepsy, Convulsions			

Personal History (PLEASE ANSWER ALL QUESTIONS) **Comment on all positive answers in the space below or attach additional page**

Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No
Scarlet fever			Frequent anxiety			Chronic cough			Venereal disease		
Measles			Frequent depression			Palpitations (heart)			Albumin/Sugar in urine		
German measles			Worry or Nervousness			High or Low Blood Pressure			Frequent Urination		
Mumps			Recurrent Headache			Rheumatic Fever or Heart Murmur			**Female Only**		
Chicken Pox			Recurrent Colds			Disease or Injury of Joints			Irregular Periods		
Malaria			Head Injury with Unconsciousness			Trick Knee, Shoulder, etc.			Sever Cramps		
Gum or tooth trouble			Hay Fever, Asthma			Back Problems			Excessive Flow		
Tuberculosis			Sinusitis			Tumor, Cancer, Cyst			**Comments:**		
Diabetes			Shortness of Breath			Jaundice					
Ear, eye, nose, throat trouble			Pain/Pressure in Chest			Stomach or Intestinal Trouble					
Surgery			Are you Allergic to:			Gallbladder Trouble or Gallstones					
Appendectomy			Penicillin			Recurrent Diarrhea					
Tonsillectomy			Sulfonamides			Rupture, Hernia					
Hernia Repair			Serum			Recent Gain or Loss of Weight					
Other			Foods (which)			Dizziness, Fainting					
Insomnia			Other			Weakness, Paralysis					

	Yes	No		Yes	No
A.Has your physical activity been restricted during the past five years?			C.Do you take any prescription medication? If so, please list.		
B.Have you received treatment or counseling for a nervous condiction, personality or character disorder, or emotional problem? (Give Details)			D.Have you had any illness or injury or been hospitalized other than already noted? (Give Details)		

I acknowledge that the above information is correct.

Signed_____Date_____

4/2020