**STUDENT HEALTH CENTER**
**The University of West Florida**
**11000 University Parkway, Bldg. 63**
**Pensacola, Florida 32514-5750 USA**

# Medical History Form

It is **REQUIRED** that this form be completed prior to registration and returned to the Student Health Center, The University of West Florida, 11000 University Parkway, Pensacola, Florida 32514 Building #63. This information is confidential and will be used as a background for providing health care. Information contained herein will not be released without your consent. Your Student Health Center, located on campus, is here to provide general medical health care and health education. All currently enrolled full-time and part-time students and their spouses and children are eligible to use the clinic for their medical needs.

FULL NAME: _____
(type or print) Last/Family First/Given Middle Maiden

Social Security Number: _____ Date of Birth: _____ Sex: _____
Month/Day/Year

Campus Address: Bldg: _____ Room: _____ P.O. Box: _____ Phone: _____ Race: _____

Local Address: _____ Phone: ( ) _____
Street Address (Mailing Address) City State Zip

Permanent Address: _____ Phone: ( ) _____
Street Address (Mailing Address) City State Zip

Emergency Contact: _____ Relationship: _____ Phone: ( ) _____

Do you have, have you ever had, or are you now taking treatment for any of the following? Check Yes or No.
Explain "Yes" answers below in the comment section.

| | | | |
|---|---|---|---|
| 1. Rheumatic Fever | ____ No ____ Yes | 9. Backache | ____ No ____ Yes |
| 2. Asthma | ____ No ____ Yes | 10. Joint trouble | ____ No ____ Yes |
| 3. Diabetes | ____ No ____ Yes | 11. Major surgery or injury | ____ No ____ Yes |
| 4. Tuberculosis | ____ No ____ Yes | 12. Severe headache | ____ No ____ Yes |
| 5. Heart disease | ____ No ____ Yes | 13. Epilepsy | ____ No ____ Yes |
| 6. Polio | ____ No ____ Yes | 14. Emotional problems | ____ No ____ Yes |
| 7. Chronic Respiratory | ____ No ____ Yes | 15. Other disease or illness | ____ No ____ Yes |
| 8. High Blood Pressure | ____ No ____ Yes | | |

16. Do you have any illness or medical condition that requires regular treatment? ____ No ____ Yes
17. Do you have a handicap or disability that you want us to know about? ____ No ____ Yes
18. Is there any reason for restriction of your activity at UWF? ____ No ____ Yes
19. Do you wear contact lenses? ____ No ____ Yes
20. Do you smoke/have you ever smoked? ____ No ____ Yes
21. List any medication (including Birth Control Pills), etc. that you are currently taking.

_____

ALLERGIES: Medications: _____
Other Allergies: _____
COMMENTS:_____

Students answering yes to questions #17, please contact Disabled Student Services (474-2387) or the Health Center
Date of last TETANUS booster (within last 10 years): _____
All statements above are true to my knowledge. I hereby grant permission to the UWF Health Center, its personnel and/or its consulting physicians, to render to me/my child, any emergency treatment or medical or surgical care that might be deemed necessary to mine/his/her health, welfare, and well being.

_____ _____
Student's Signature Date

_____ _____
Parent or Legal Guardian's Signature Date

**REQUIRED**: Authorization for treatment if under age of 18.