THOMAS MORE
UNIVERSITY

(Please print all information) **For All Students**

Medical History

PLEASE EMAIL OR FAX COMPLETED FORM TO:

EMAIL: schatzt@thomasmore.edu/ FAX: 859-344-3636

Student ID #: _____ University Status: ____Fresh ____ Soph ____Jr ____Sr ____Int'l

Resident or Commuter **(circle)** Date of Birth_____

Name: _____
Last First MI Maiden

Address: _____
City State Zip Code

Home Phone: _____ E-mail: _____
Cell Phone: _____

Emergency Contact (capable of giving permission for treatment in an emergency)

Name: _____Relationship_____

Phone: (H) _____ (W) _____ (Cell) _____

Primary Care Physician

Phone: _____

Health Insurance

Do you have health insurance? ___Yes ___No
Carrier: _____ Policy #/Group # _____

Policy Holder: _____

List all medications you currently take on a daily basis, or just as needed:

_____

_____

_____

List **ALL** drug allergies, your reaction and the last time you reacted:

_____

_____

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Medical History

Please indicate, by checking the yes or no box, if you have a recent history of:

Yes	No		Yes	No	
		Frequent or Severe Headaches			Recurrent Back Pain
		Dizziness or Fainting Spells			Sprains and/or Strains
		Head Injury			High or Low Blood Pressure
		Skin Disease or Condition			Depression or Extreme Worry
		Jaundice or Hepatitis			Treatment for a Mental Health Condition
		Paralysis			Sexually Transmitted Infections
		Epilepsy or Seizures			Glasses or Contacts
		Diabetes type I or type II (please circle)			Broken Bones
		Hearing Loss			Heart Disorder(s)
		Hearing Aid			Sinusitis
		Asthma			Seasonal Allergies
		Allergy Injections			Tobacco Use
		Tuberculosis			Drug and/or Alcohol Abuse History
		Positive TB Skin Test			Eating Disorder
		Recent weight loss or weight gain			

Please elaborate on any item answered yes:

_____

_____

Please note any injury or illness not listed above:

_____

Immunizations
All student must provide a complete copy of childhood immunizations. You may ask your physician's office to fax a copy of your immunizations to the Campus Health Center at (859) 344-3636.

Privacy

The information contained within this document is strictly for the use of the Campus Health Center and will not be released to anyone without your written consent. My protected health information will not be shared with professors or other college personnel without my written authorization.

I understand that Health Services may consult with colleagues to ensure quality treatment and continuity of care, including counseling staff and other clinical personnel (e.g. athletic training staff) who may be part of the treatment team.

I understand that I have the right to restrict the use and disclosure of my protected health information, and that I may revoke my consent at any time by giving written notification.

____ YES _____ NO I consent to information regarding my care to be transmitted electronically (e.g. through TMU email). I provide consent to participate in telehealth visits.

I certify that the above information is true and complete to the best of my knowledge. I give the Thomas More University Campus Health Center consent to perform routine medical care and necessary emergency care procedures; and to use their best judgment in securing emergency medical aid and/or transportation. I understand that I am financially responsible for any and all medical expenses incurred.

Student or Parent signature if under 18 _____Date_____

_____

Student Signature Date

_____

Parent Signature - if student is under 18 Date