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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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.

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 Signature Date

_____

Parent Signature - if student is under 18 Date