

Complete this form and sign at the bottom.

SUMMER CAMPS
HEALTH SERVICES
The University of Texas at Arlington
www.uta.edu/healthservices
REPORT OF MEDICAL HISTORY

This form is a part of your health record and will be kept private in accordance with HIPAA regulations.

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Campers Last Name (Print) _____ First _____ Middle _____ Date of Birth _____ Gender _____

Local Address _____ City/State/Zip Code _____ Home Phone _____ Country of Birth _____

In case of emergency, please contact: _____ Phone number: _____

Family History: Have any blood relatives ever had the following:

	Yes	No	Relationship		Yes	No	Relationship
Cancer				Epilepsy, Convulsions			
Diabetes				High Blood Pressure			
Heart Disease				Tuberculosis			

Personal History: Please answer all questions. Have you ever had or do you now have:

	Yes	No		Yes	No		Yes	No		Yes	No	
Measles			Shortness of Breath			Rheumatic Fever/Heart Murmur			Head Injury with Unconsciousness			
German Measles			Gallbladder Problem/Gallstones			Rupture, Hernia			High or Low Blood Pressure			
Mumps			Hepatitis			Disease or Injury of Joints or Back			Blood Clotting Disorder			
Tuberculosis			Recent Weight Gain/Loss			Tumor, Cancer, Cysts			Urinary Tract Condition			
Arthritis			Pain/Pressure in Chest			Alcohol Consumption			Kidney/Bladder			
Epilepsy, Convulsions			Anemia			Sickle Cell Disease or Trait			Stomach/Intestinal Problem or Ulcers			
Asthma, Hay Fever			Palpitations (Heart)			High Cholesterol			Immune Deficiency			
Eye Disease			Weakness, Paralysis			Surgeries - List			Allergies – Drugs or other			
Smoker			Stroke									
Ear/Nose/Throat Problem			Dizziness, Fainting									
A. Are you currently under the care of a physician?												
B. Are you taking any medication for heart disease or high blood pressure? List:												
C. Are you currently taking any other prescription medication on a routine basis? List:												

Women's Clinic: (Optional)

Gynecological History	Yes	No		Yes	No		Yes	No
Is this your first Pap			Pain during Intercourse			Severe Cramps/Pain during Period		
History of STDs			Breast Disease			Pelvic infections (Uterus/Tube/Ovaries)		
Abnormal Bleeding			Cancer			Have Period every Month		
Age Periods began:						Abnormal Pap:		
Duration of Period:						Treatment:		
Birth Control Methods used:						Other:		

STATEMENT OF AUTHORIZATION

I authorize UT Arlington Health Services to administer medical and surgical treatment and to perform routine and emergency diagnostic and therapeutic procedures as deemed necessary by duly licensed medical personnel.

Signature of Patient Date

Signature of Parent of Guardian Date
(required if patient is under age of 18)

NOTE: Surgery, fractures, sophisticated diagnostic procedures and hospitalization in local hospitals for complicated medical care is not covered by the Summer Camp Fee.