

Complete this form and sign at the bottom. Page two is for our use only.

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.

M F

 Last Name (Print) First Middle Date of Birth Gender UT Arlington I.D. Number

 Local Address City/State/Zip Code Home and Work Phone Numbers Country of Birth

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

Are you covered by UT Arlington Student Insurance? Yes No If yes, please list date of coverage: _____

Are you covered by other Insurance? Yes No If yes, please list company name: _____

***If we accept your insurance, do you authorize us to submit claims for services rendered?** Yes No

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:

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/Tubes/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 or Guardian Date
(required if patient is under age 18)

NOTE: Surgery, fractures, sophisticated diagnostic procedures and hospitalization in local hospitals for complicated medical care is not covered by the Medical Services Fee. Supplemental insurance is available for purchase at The University of Texas at Arlington and is recommended for students not covered by other insurance plans.

REPORT OF HEALTH EVALUATION

(UT Arlington Health Services Use Only - health evaluation not necessary for admission to UT Arlington)

TO THE EXAMINING PHYSICIAN: Please review the patient's history and complete the physician's form. Please comment on all positive answers. This information is strictly for the use of the UT Arlington Health Services and will not be released without patient consent.

LAST NAME _____	FIRST NAME _____	MIDDLE _____
BP _____/_____	Height _____ inches	Weight _____ lbs.
Corrected Vision _____	Tuberculin Skin Test: Positive _____ Negative _____	Date _____
Right 20/_____	Left 20/_____	

Laboratory procedures (if indicated):

Urinalysis

Hematology

Sugar _____
 Albumin _____
 Micro. _____

Hgb. _____ gms%
 Hct. _____ %

Are there abnormalities of the following systems? Describe fully. Use additional sheets if needed.

	Yes	No
Head, Ears, Nose, Throat		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Eyes		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neuropsychiatric		
Skin		

Is there loss or seriously impaired function of any paired organ? Yes ___ No ___
 Do you have any recommendations regarding the care of this student? Yes ___ No ___
 Is the patient now under treatment for any medical or emotional condition? Yes ___ No ___
 Have you any general comments?

Recommendations for physical activity (PE, Intramurals, ROTC)
 Unlimited ___ Limited ___ Explain: _____

Physician's Signature _____ Address _____
 Printed Name _____

Immunization Information: Proof of the following is requested but not required:

	DATE		DATE		DATE
Tetanus/Diphtheria (every 7 - 10 yrs)	_____	Hepatitis B	_____	1st	Measles Vaccine/disease _____
Oral Trivalent Polio	_____		_____	2nd	Mumps Vaccine/disease _____
Meningococcal Meningitis	_____		_____	3rd	Rubella Vaccine/disease _____

TB Skin Test DATE RESULT **or** Chest X-Ray DATE RESULT

_____ _____ _____ _____ _____ _____ _____