HEALTH HISTORY
MOREHEAD STATE UNIVERSITY

Counseling & Health Services
150 University Blvd.
Morehead, KY 40351
606-783-2055

To be completed by patient unless under the age of 18 then must be completed and signed by parent/guardian.
Completion of this report is required before treatment at the Counseling and Health Services Clinic at Morehead State University. All health information is confidential and will be placed on file in the Health Clinic. Please read carefully and answer all questions on the form. Consult your parents/guardian for complete and accurate information. You may need to consult your family health care provider or public health department for accurate immunization record.

Name____
Last **First** **Middle**

Social Security Number_______________**Date of Birth**____/____/_____ **Age**____ **Male**___ **Female**___
Month **day** **year**

Home address____ **Phone**______________
Number & Street **City** **State** **Zip**

Medical History Place an x in the appropriate yes or no column for each item listed and indicate year for each yes response. If any medical condition still exists for which a yes response was given , please give further detail at the end of the form.

CONDITION	YES	NO	YEAR	CONDITION	YES	NO	YEAR
Measles				Tuberculosis			
Mumps				Mental health (bipolar, depression, ADD, anxiety, etc.)			
Chicken Pox				Meningitis			
Mononucleosis				Seizures or convulsions			
Anemia or blood disorder				Paralysis			
Heart murmur/heart disease				Severe Headaches			
Rheumatic fever				Head injury or concussion			
High Blood Pressure				Stomach/intestinal trouble			
Clots in veins				Ulcer			
Gynecological problems				Hepatitis (yellow jaundice)			
Sexually Transmitted disease				Gallbladder disease			
Asthma				Thyroid disease			
Pneumonia				Diabetes			
Orthopedic injuries/fractures/surgeries				Bladder/kidney disease			
Cancer							

Have you had any illness, injury, or hospitalization not already noted? _____yes _____no. If yes, please explain
Have you ever had surgery? _____yes _____no. If yes, indicate date and type of operation:____
____

Are you allergic to any medications? ____yes ____no. If yes, indicate medications:
____penicillin ____tetracycline ____sulfa ____others (specify):

Are you presently taking any medication? ____yes ____no. If yes, list name of drug, dosage, strength, and frequency:

Do you use tobacco products? ____yes ____no

Have you had the following vaccinations? If yes, please supply dates or attach copy of immunization record from health care provider.

Immunization	YES	DATE (month/date/year)-*please list all dates*	NO
Diphtheria, Tetanus, and Pertussis (DPT)			
Td or Tdap (please specify)			
Oral Polio Vaccine			
MMR (measles, mumps, rubella)			
Chickenpox			
Hepatitis B			
Meningitis Vaccine			
Have you had a tuberculin skin test (TB skin test)?		**POSITIVE NEGATIVE**	
If TB skin test was positive, have you had a chest x-ray?			
Please give date and result if had chest x-ray			
If you are an international student or have lived outside of the United States, have you received BCG? (vaccine for tuberculosis)			
Have you lived in a household with anyone who has had tuberculosis? If yes, please explain			

Medical Personnel of Counseling and Health Service will review this health history. You will be notified in writing if further medical information is needed.

Please list the name of your personal health care provider as well as phone number and fax if available

____

By signing your name, MSU student ID number or social security number if no student ID, and date, you are certifying that all information is true and correct to the best of your knowledge. You are also consenting to examination and treatment by Morehead State University Counseling and Health Services staff and Dental staff. There may be additional consent forms required for release of information. This consent shall be continuing until revoked in writing. You are granting permission for Morehead State University Counseling and Health Services and Morehead State University Dental Services to use and disclose health information in order to carry out treatment, payment and health care operations as stated in Authorization and Notice of Medical Information Disclosure and Access.

You are also consenting for Morehead State University Counseling and Health Services and Morehead State University Dental Services to bill your insurance.

Student Signature______________________________ **Date**__________

MSU ID/SSN______________________________

ADDITIONAL INFORMATION

Person to be notified at patient request in case of illness:____________________

Please list name with day and evening phone numbers____________________

MEDICAL CONSENT-FOR MINORS ONLY UNDER 18 YEARS OF AGE

By signing your name as parent or guardian, the student's name and student's date of birth, you are hereby consenting to having qualified medical personnel and/or dental personnel render to my son or daughter medical, dental and emergency treatment and/or surgical care, and services offered through Counseling and Health Services, as deemed necessary to his or her health and well-being. You grant permission for the hospitalization of your son or daughter when necessary for implementing proper medical care. There may be additional consent forms required for release of information. This consent shall be continuing until revoked in writing. I give permission for my child to obtain counseling services independently, without notification of parent or guardian. When expressed concerns involve danger to self or others, parent or guardian will be notified.

You also grant permission for Morehead State University Counseling and Health Services and Morehead State University Dental Services to use and disclose health information about your son/daughter in order to carry out treatment, payment and health care operations as stated in Authorization and Notice of Medical Information Disclosure and Access.

You are also granting permission for Morehead State University Counseling and Health Services and Morehead State University Dental Services to bill your insurance.

Parent/Guardian Signature ________________________________ **Date** ______________

Student Name____ **Student Date of Birth**____________

INSURANCE/PAYMENT INFORMATION

Counseling and Health Services is doing business as a family practice clinic and dental services clinic as well as addressing minor urgent care issues. Please provide a copy of your insurance card at time of service, as it is the responsibility of the student to obtain health insurance. We now provide third party billing. In order to bill your insurance, we will also need the policy holder's name, date of birth, and last four digits of social security number. If no insurance is available, students will still be eligible to receive health care at the clinic.

If insurance is available on the student, please list. If no insurance, type N/A:

Name of insurance:____

Group #:____

Policy or ID #:____

Policy Holder's Name:____

Policy Holder's Date of Birth:____

Last 4 Digits of Policy Holders Social Security #:______________________________

Policy Holder's Home Address:____

Address and/or phone number to send claims (should be found on back of insurance card):____