Tougaloo College Owens Health and Wellness Center

MEDICAL RECORD FORM

Last Name **First Name** **Middle Name** **Date of Birth**

Street Address **City** **State** **Zip**

Gender: ☐ Male ☐ Female **Marital Status**: ☐ Married ☐ Single ☐ Widow(er) ☐ Divorced

Social Security Number: _____ **U.S. Citizen**: ☐ Yes ☐ No **Religion**: _____

Parent, Guardian, or Spouse Name (if applicable) **Area Code and Telephone Number**

Have you had or do you have any of the following? All sections must be completed.

Infectious Diseases

Yes	No	
☐	☐	AIDS/HIV Infection
☐	☐	Frequent Conjunctivitis
☐	☐	Chicken Pox
☐	☐	Meningitis
☐	☐	Infectious Mononucleosis
☐	☐	Rheumatic Fever
☐	☐	Whooping Cough
☐	☐	Measles/Rubella

Cardiovascular Diseases

Yes	No	
☐	☐	High Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Angina Pectoria
☐	☐	Thrombophlebitis

Hematologic Disorders

Yes	No	
☐	☐	Anemia
☐	☐	Sickle Cell Disease
☐	☐	Leukemia
☐	☐	Hemophilia

Metabolic/Endocrine Disorders

Yes	No	
☐	☐	Diabetes
☐	☐	Obesity
☐	☐	Goiter
☐	☐	Thyroid Disease

Urinary Track Disorders

Yes	No	
☐	☐	Frequent Urinary Tract Infections
☐	☐	Kidney Stones
☐	☐	Pyelonephritis

Infectious Diseases

Yes	No	
☐	☐	AIDS/HIV Infection
☐	☐	Frequent Conjunctivitis
☐	☐	Chicken Pox
☐	☐	Meningitis
☐	☐	Infectious Mononucleosis
☐	☐	Rheumatic Fever
☐	☐	Whooping Cough

Digestive System Disorders

Yes	No	
☐	☐	Gallbladder Diseases
☐	☐	Ulcerative Colitis
☐	☐	Crohn's Disease
☐	☐	Frequent Indigestion
☐	☐	Irritable Bowel Syndrome
☐	☐	Hemorrhoids
☐	☐	Gastritis
☐	☐	Hepatitis/Jaundice
☐	☐	Peptic Ulcer Disease

Nervous System Disorders

Yes	No	
☐	☐	Epilepsy
☐	☐	Frequent headaches
☐	☐	Glaucoma
☐	☐	Dizziness/Fainting Spells
☐	☐	Hay Fever
☐	☐	Allergies (Food, Medicine)
☐	☐	Sleep Disorders
☐	☐	Alcohol/Drug Addition
☐	☐	Visual Problems

If yes, describe: _____

Yes	No	
☐	☐	Do you wear glasses?
☐	☐	Do you sleep walk
☐	☐	Do you have dental cavities?

Yes	No	
☐	☐	Do you live with someone who has Tuberculosis?
☐	☐	Are you taking medication for Tuberculosis?
☐	☐	Have you ever taken medication for Tuberculosis?

Are you allergic to any medicine? If yes, please list:

Are there any other health conditions for which you are or were under a doctor's care?

Yes	No	
☐	☐	Have you ever consulted or been treated by a psychiatrist? If yes, list the name and address of the physician.

Yes	No	
☐	☐	Have you ever been a patient in a mental hospital or sanitarium?

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.

Signature Date

TC1869

Tougaloo College Owens Health and Wellness Center

Supplemental Medical Record Form

Student Name _____

1. Do you have any allergies? Please List. _____

   If yes, what medicine(s) do you take? _____

2. Have you ever been told that you have diabetes (sugar)? ☐ Yes ☐ No

3. Have you ever been told that you have hypertension (high blood pressure)? ☐ Yes ☐ No

   If yes, what medicine do you take to treat high blood pressure?_____

4. Have you been told that you have Sickle Cell Anemia? ☐ Yes ☐ No

5. Do you wear a BRACE on your shoe, knee, back, etc? ☐ Yes ☐ No

6. Have you ever had seizures? ☐ Yes ☐ No

   If yes, what medicine do you take to treat seizures? _____

7. What medicine(s) do you take that require a prescripition?

   _____

8. What medicine(s) do you take that do not require a prescription?

   _____

9. Have you ever had surgery? ☐ Yes ☐ No If yes, please list the type and date of each surgery.

   _____ _____
   _____ _____
   _____ _____

10. Do you have medical insurance (i.e., Medicaid, Blue Cross/Blue Shield, etc.)? ☐ Yes ☐ No

    If yes, provide insurer name, address, and insured ID number _____

    _____

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Student Emergency Information Contact Form

Instructions: Please print and complete all of the requested information. **Please, check this box if you are homeless.** ☐

Student's Name _____ Date of Birth __/___/_____/_____

Social Security Number _____Home Phone Number _____/____/_____

Mobile Number _____ Allergies_____

Parent/Guardian's Name_____
First Middle Last

Parent/Guardian's Name_____
First Middle Last

Permanent Address_____
Street City State Zip Code

Emergency Contact Person _____
First Middle Last

Emergency Contact Home Phone _____/_____/_____ Mobile Number _____/_____/_____

Student's Medical Insurance Company _____

Company/Claim Address_____/_____/_____/_____
Street City State Zip Code

Company Phone Number _____/_____/_____ Facsimile _____/_____/_____

Policy Holder's Name _____

Policy Number _____ Group Number _____

Co-Pay or Deductible for Primary Care Provider/Physician _____Specialist_____

Student's Signature _____Date _____

Parent or Guardian's Signature _____ Date _____
(*if student is 17 years old or younger*)