

Texas A&M International University Student Health Services Health History Form

Date of birth: Gender: Male/Female/Trans/Nonbinary/No answer Address: Zip Code: Zip Code:		Student ID:			Name:
City, State:	swer	Male/Female/Trans/Nonbinary/No a	Gender:		Date of birth:
Phone: (home)		·			Address:
Health insurance: YES or NO Insurance provider: Emergency contact:		Zip Code:			City, State:
Emergency contact:		I)	(cell		Phone: (home)
Emergency contact phone: (home)			der:	: YES or NO Insurance provid	Health insurance:
MEDICAL HISTORY Medical conditions you have been diagnosed with: Are you currently under the care of a doctor: YES or NO Name of doctor: Allergies: YES or NO Please list here: Medications: Have you had surgery: YES or NO Please list here: Family History Y N Member of family with illness/disease Alzheimer's Breast cancer Coronary disease Coronary diseas		Relationship:		ct:	Emergency contac
Medical conditions you have been diagnosed with: Are you currently under the care of a doctor: YES or NO Name of doctor: Allergies: YES or NO Please list here: Medications: Have you had surgery: YES or NO Please list here: Family History Y N Member of family with illness/disease Alzheimer's Breast cancer Coronary disease		_ (cell)		ct phone: (home)	Emergency contac
Are you currently under the care of a doctor: YES or NO Name of doctor: Allergies: YES or NO Please list here: Medications: Have you had surgery: YES or NO Please list here: Family History Y N Member of family with illness/disease Alzheimer's Breast cancer Coronary disease Coronary diseas				<u>RY</u>	MEDICAL HISTORY
Name of doctor: Allergies: YES or NO Please list here: Medications: Have you had surgery: YES or NO Please list here: Family History Y N Member of family with illness/disease Alzheimer's Breast cancer Coronary disease			th:	ns you have been diagnosed wit	Medical condition
Allergies: YES or NO Please list here: Medications: Have you had surgery: YES or NO Please list here: Family History Y N Member of family with illness/disease Alzheimer's Breast cancer Coronary disease C	a currently under the care of a doctor: YES or NO				
Medications: Have you had surgery: YES or NO Please list here: Family History Y N Member of family with illness/disease Alzheimer's Breast cancer Coronary disease Cervical cancer Colon cancer Depression Diabetes Glaucoma Married Social History Married Single Divorced Widow(er) Lives Alone Separated Do you: Smoke - YES or NO Drink Alcohol - YES or NO	·	Name of doctor: _			
Have you had surgery: YES or NO Please list here: Family History	Please list here:				Allergies: YES or N
Have you had surgery: YES or NO Please list here: Family History Y N		Medications:			
Y N Member of family with illness/disease □ Alzheimer's □ Breast cancer □ Coronary disease □ Divorced □ Cervical cancer □ Divorced □ Colon cancer □ Lives Alone □ Depression □ Do you: Smoke - YES or NO □ Diabetes □ Dirink Alcohol - YES or NO □ Glaucoma Use recreational drugs - YES or NO					
□ Alzheimer's Social History □ Breast cancer □ Married □ Single □ Coronary disease □ Divorced □ Widow(er) □ Colon cancer □ Lives Alone □ Separated □ Depression □ Diabetes □ Diabetes □ Drink Alcohol - YES or NO □ Glaucoma Use recreational drugs - YES or NO					
□ Breast cancer □ Married □ Single □ Coronary disease □ Divorced □ Widow(er) □ Colon cancer □ Lives Alone □ Separated □ Depression □ Diabetes □ Diabetes □ Drink Alcohol - YES or NO □ Glaucoma Use recreational drugs - YES or NO		cial History	e Soci	Member of family with illness/disease	
□ Coronary disease □ Divorced □ Widow(er) □ Colon cancer □ Lives Alone □ Separated □ Depression □ Diabetes □ Do you: Smoke - YES or NO □ Glaucoma □ Glaucoma □ Use recreational drugs - YES or NO					
☐ Colon cancer ☐ Depression ☐ Diabetes ☐ Glaucoma ☐ Lives Alone ☐ Separated ☐ Do you: Smoke - YES or NO ☐ Drink Alcohol - YES or NO ☐ Use recreational drugs - YES or NO		•			☐ ☐ Coronary disease
□ □ Colon cancer □ □ Depression □ □ Diabetes □ □ Glaucoma □ □ Glaucoma □ □ Colon cancer □ □ Do you: Smoke - YES or NO □ □ Use recreational drugs - YES or NO					□ □ Cervical cancer
□ □ Diabetes □ □ Do you: Smoke - YES or NO □ □ Glaucoma □ □ Smoke - YES or NO □ □ Use recreational drugs - YES or NO		Lives Alone in Separated	"		
☐ ☐ Glaucoma ☐ ☐ Use recreational drugs - VES or NO		you: Smoke - YES or NO	Do		
Ilse recreational drugs - VES or NO					
u u піgii cilolesterol		Use recreational drugs - YES or NO			
□ □ High blood pressure					_
□ □ Ovarian cancer					
Do you have children? YES or NO					
□ □ Seizure disorder Number of children:		mber of children:	Nun		
□ □ Skin cancer					
☐ ☐ Thyroid dysfunction or N	or NONE	ligious Preference:	Reli		
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Updated June 2024 SHS-3

Signature: