

RHODES MEDICAL HISTORY FORM

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This form is to be completed and signed by the incoming student or parent.

Return this form by June 15th to:
 Rhodes College
 Student Health Center
 2000 N. Parkway
 Memphis, TN 38112

Students Name _____ Birthdate _____

Family Medical History

Please indicate any items that apply to your parents, siblings or grandparents.

| Disease | Family Member | Disease | Family Member |
|---------------------|---------------|---------------|---------------|
| High Blood Pressure | | Diabetes | |
| Bleeding tendency | | Heart Disease | |
| Anemia | | Tuberculosis | |
| Sickle Cell Anemia | | HIV | |
| Mental Illness | | Seizures | |
| Cancer | | Other: | |

Current Medications

Please list any antibiotics, antidepressants, birth control pills, inhalers, vitamins, minerals and any herbal/natural product (prescription and nonprescription) that you current use and how often you use them.

| Name | Dose | Frequency | Use |
|------|------|-----------|-----|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Hospitalizations/Surgeries

Please list date and reason for any hospitalizations or surgeries.

| Date | Reason | Comments |
|------|--------|----------|
| | | |
| | | |
| | | |

Allergies

Please indicate any allergies and reactions you experienced to:

Medications _____

Environmental _____

Food _____

Are you allergic to latex? Yes _____ No _____

'I do not have any known allergies.' If this is correct, please initial here _____

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 Fax: 901-843-3134

Social History

Please indicate if you use any of the following:

Cigarettes/Cigars/Dip Yes_____ No_____ Pack or Amount per Day _____
 Alcohol Yes_____ No_____ Drinks per Week _____
 Caffeine Yes_____ No_____ Cups per Day _____

Personal History

Please indicate the presence of absences of a personal history of all of the following. If you answer yes to any of these items, please indicate the approximate year in which they occurred.

| Disease | History | Year | Disease | History | Year | Disease | History | Year |
|-----------------------|---------|------|-------------------------|---------|------|------------------------------------|---------|------|
| Anemia | Y / N | | Tuberculosis | Y / N | | Recurrent Urinary Infections | Y / N | |
| Bleeding Tendency | Y / N | | Bronchitis | Y / N | | Mumps | Y / N | |
| Phlebitis/Blood Clots | Y / N | | Pneumonia | Y / N | | Measles | Y / N | |
| High Blood Pressure | Y / N | | Sickle Cell Anemia | Y / N | | German Measles | Y / N | |
| Thyroid Problems | Y / N | | Depression | Y / N | | Cancer | Y / N | |
| Hypoglycemia | Y / N | | Mental Illness | Y / N | | Menstrual Irregularities | Y / N | |
| Diabetes | Y / N | | Epilepsy/Seizures | Y / N | | Hernia | Y / N | |
| Chicken Pox/Shingles | Y / N | | Neurological Disorders | Y / N | | Skin Problems | Y / N | |
| Strep Throat | Y / N | | Vision Problems/Glasses | Y / N | | Ulcers/Stomach/Intestinal Problems | Y / N | |
| Mononucleosis | Y / N | | Eating Disorder | Y / N | | Back Problems | Y / N | |
| Sinus Problems | Y / N | | Concussion/Head Injury | Y / N | | Orthopedic Issues | Y / N | |
| Allergies/Hay Fever | Y / N | | Headaches/Migraines | Y / N | | Rheumatic Fever | Y / N | |
| Asthma | Y / N | | Hearing Problems | Y / N | | Other: | Y / N | |

Student Signature _____ Date _____