RHODES MEDICAL HISTORY FORM

This form is to be completed and signed by the incoming student or parent by JUNE 15th.

Mail this form to Rhodes College, Student Health Center
2000 N. Parkway, Memphis, TN 38112
Or email a scanned PDF to: **health-forms@rhodes.edu**

Student's Name____________________________ D.O.B.____________________ Rhodes ID________

Family Medical History

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

Disease	Family Member	Disease	Family Member
High Blood Pressure		Diabetes	
Bleeding tendency		Heart Disease	
Anemia		Tuberculosis	
Sickle Cell Anemia		HIV	
Mental Illness		Seizures	
Cancer		Depression	
ADD/ADHD		Other:	

Current Medications

Please list any antibiotics, antidepressants, birth control pills, inhalers, vitamins, minerals and any herbal/natural product (prescription and nonprescription) that you currently 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 experience 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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Social History

Please indicate if you use any pf the following:

Cigarettes/Cigars/Dip	Yes____ No____	Pack of Amount per Day __________________
Alcohol	Yes____ No____	Drinks per Week__________________________
Caffeine	Yes____ No____	Cups per Day_____________________________

Personal History

Please indicate the presence or 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	
Depression	Y / N		DD/ADHD	Y/ N				

Student Signature____ Date______________________