**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 to Rhodes College, Student Health Center

2000 N. Parkway, Memphis, TN 38112

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 |  | Thyroid |  |

**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 Type:\_\_\_\_\_\_\_\_\_ | Y / N |  |
| Hypoglycemia | Y / N |  | Mental Illness Type:\_\_\_\_\_\_\_\_\_\_\_\_\_ | 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 Type:\_\_\_\_\_\_\_\_\_ | 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 Type:\_\_\_\_\_\_\_\_\_ | Y / N |  |
| Sinus Problems | Y / N |  | Concussion/Head Injury | Y / N |  | Orthopedic Issues Type:\_\_\_\_\_\_\_\_\_ | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_