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McKinley Health Center
Student Affairs/University of Illinois
at Urbana-Champaign

MEDICAL HISTORY FORM

(please print / type)

Last Name	First Name	Middle Name	UIN
Date of Birth	Sex/Gender	Country of Birth ()	
Permanent Address	City	State	Zip Code Telephone ()
Local Address	City	Zip Code	Preferred Local Telephone

Check One:

<input type="checkbox"/> African American	<input type="checkbox"/> Hispanic	If English is not your primary language, specify primary spoken language _____
<input type="checkbox"/> Asian or Pacific Islander	<input type="checkbox"/> Native American/ Alaskan Native	
<input type="checkbox"/> Caucasian	<input type="checkbox"/> Other _____	Religious Affiliation _____
<input type="checkbox"/> East Indian		

In Case of Emergency, Notify:

Name	Relationship	Telephone ()
Address	City	State Zip Code

HAVE YOU HAD:	YES	NO	HAVE YOU HAD:	YES	NO
Head Injury with Unconsciousness			Sexually Transmitted Disease		
Asthma			Malaria		
Recurrent Headaches			Chicken Pox		
Seizure Disorder			Scarlet Fever		
Hearing Loss			Hay Fever		
Recurrent Ear Infections			Rheumatic Fever		
Visual Problem (other than glasses)			High Cholesterol		
Thyroid Problem			Hepatitis A,B, or C		
Heart Problem/Murmur			Diabetes		
Kidney/Urinary Tract Problem			High Blood Pressure		
Gynecology Problem(s)			Digestive Tract Problem		
Recent Weight Change			Cancer/Tumor/Cyst		
Bleeding/Blood Disorder			Spinal Cord Disruption		
Tuberculosis			Eating Disorder		

ALLERGIES to Drugs/Medications: (write NONE if none)	Other Allergies (i.e., environmental): (write NONE if none)	Routine Medications Taken: (write NONE if none)
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CONTINUED ON REVERSE SIDE

MEDICAL HISTORY FORM, continued

Last Name

First Name

UIN

Family Member	Occupation	Health Status Excellent/Average/Poor	Age	If no longer living, Cause of Death & Age at Death
Father				
Mother				
Brothers				
Sisters				
Spouse/Partner				
Children				

HAS ANY FAMILY MEMBER EVER HAD:

(parent, sibling, or grandparent)

YES

NO

Relationship

YES

NO

Relationship

Tuberculosis				Asthma			
Drug/Alcohol Abuse				Thyroid Disease			
Diabetes				Seizure Disorder			
Kidney Disease				Blood Disorder			
Heart Disease				Cancer			
High Blood Pressure				Stroke			
Arthritis				Obesity			
Stomach Disease				Other			
High Cholesterol							

OTHER CONCERNS/INFORMATION:

Student Signature

Date

