



FLORIDA GULF COAST UNIVERSITY
STUDENT HEALTH SERVICES

Phone: (239) 590-7966
Fax: (239) 590-7968

Medical History

Name: (Last, First, Middle) FGCU ID #

Date of Birth: / / Age: Gender: E-mail:
Cell Phone: () Home Phone: ()

Local Address: (Street) (City) (State) (Zip)

Permanent Address: (Street) (City) (State) (Zip)

Person to notify in case of emergency: Relationship to you:
Phone: () Address: (Street) (City) (State) (Zip)

FAMILY HISTORY (Parents, Siblings, Grandparents) Check where applicable

- Alcoholism, Anemia, Arthritis, Asthma, Blood Disorder, Cancer, Convulsions, Diabetes, Epilepsy, Heart Disease, High Blood Pressure, Kidney Disease, Mental Illness, Migraines, Sickle Cell, Stroke, Sudden Death, Tuberculosis, Other (Specify)

PERSONAL HISTORY check where applicable

- Arthritis, AIDS/HIV, Alcoholism, Anemia, Anxiety, Asthma, Bladder/Kidney Infection, Blood Disorder, Cancer, Cardiac Abnormalities, Chronic Cough, Chronic Kidney Disease, Congenital Anomaly, Constipation, Depression, Diabetes, Drug Addiction, Eating Disorder, Emotional, Fainting/Dizziness, Frequent Colds, Gastrointestinal Problems, Headache, Heart Disease, Hepatitis, Hypertension/High Blood Pressure, Insomnia, Mental Illness, Migraines, Obesity, Rheumatoid Disease, Seasonal Allergies, Seizures/Epilepsy, Sickle Cell, STD, Thyroid Disease, Tuberculosis

Are you under treatment for any medical/emotional condition? (describe):

Past surgeries (describe):

Past serious illness/injury (describe):

ALLERGIES check where applicable

- No Known Drug Allergies, Aspirin, Penicillin, Codeine, Sulfa, Name of other drug: Reaction to drug: Latex, Food, Animal, Insect, Other (please specify)

MEDICATIONS check where applicable

- None, Over the Counter, Oral Contraceptives, Vitamins, Herbal, Prescription, Illicit Drugs, Other

INSURANCE INFORMATION

Do you have medical insurance? Yes No If yes, Name of company:

Reason for today's visit:

Permission is hereby granted for the FGCU Student Health Services professionals and staff to carry out indicated medical or surgical treatments. Cases requiring specialized and/or emergency care will be referred to an appropriate medical setting or professional.

Signature of Student / Parent or Legal Guardian (if minor):

Date: